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ABSTRACT

A study evaluated the effectiveness of educational preparation for mental health nursing in multi-professional, multi-agency team environments in a range of mental health settings in England. The following data collection activities were conducted: an extensive literature review; local focus groups with mental health service users, care providers, nurses and managers, multi-professional team members, tutors, and students; a national survey administered to 800 mental health care service users, providers, and students; case studies of 8 sites across England; and a national survey of 400 individuals to obtain feedback on findings obtained during earlier phases of the study. The following were among the 23 recommendations emerging from the study: (1) because teamwork is more effectively "caught" than "taught," provide students with longer clinical placements earlier in their preregistration programs; (2) place more emphasis on team-building skills; (3) promote more collaborative patterns of teamwork, both in clinical and educational settings; (4) combine teamwork-focused case studies, educational vignettes, and assignments with technical nursing issues and user perspectives; (5) give more consideration to the affective nature of

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nurses' work, both in terms of stress and in terms of vocational commitment; and (6) give ex-mental health service users greater input in policy, practice, and educational contexts. (Contains 297 references.) (MN)

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English National Board for Nursing, Midwifery and Health Visiting

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RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

Teamworking in Mental Health: zones of comfort and challenge

Sheila Stark
Ian Stronach
Tony Warne
David Skidmore
Angela Cotton
Mark Montgomery

London, 2000

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Abbreviations

A&E	Accident and emergency
ASW	Approved social worker
The Board	The English National Board for Nursing, Midwifery and Health Visiting
CFP	Common foundation programme
CMHC	Community mental health centre
CMHN	Community mental health nurse
CMHT	Community mental health team
CPA	Care programme approach
CPN	Community psychiatric nurse
DipHE	Diploma of Higher Education (previously Project 2000)
DoH	Department of Health
ENB	The English National Board for Nursing, Midwifery and Health Visiting
GP	General practitioner
HCA	Health care assistant
HE	Higher education
HImP	Health Improvement Programme
MDT	Multidisciplinary team
MHC	Mental health centre
MHN	Mental health nurse
MHUG	Mental health user group
NHS	National Health Service
NHSE	National Health Service Executive
NSF	National Service Framework
NVQ	National Vocational Qualification
OT	Occupational therapist
PCG	Primary care group
PCT	Primary care trust
PSI	Psycho-social intervention
R&R	Report-and-respond
SEMI	Severe and enduring mental illness
SW	Social worker
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Foreword

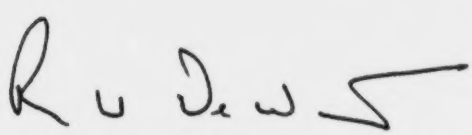
The English National Board for Nursing, Midwifery and Health Visiting is delighted to publish this report as the seventeenth in its successful series: ***Researching Professional Education.***

The Board launched this series with the aim of making widely available the results and implications of research commissioned by the Board. The series enables key stakeholders: policy makers, managers, practitioners, researchers and educators to have access to relevant and sound research from which to plan educational developments.

Multiprofessional team working is high on the Government's agenda as part of the modernisation of the NHS. ***Teamworking in Mental Health: zones of comfort and challenge*** focuses on the effectiveness of multiprofessional multi-agency teamworking in a range of mental health settings. It examines both practice and educational preparation. The research team undertook an extensive review of the literature, documentary analysis, focus groups, survey, case studies and a report-and-respond survey.

It became apparent that teamworking is situated in a 'turbulent' context in which 'soothing mechanisms' create a series of paradoxes. The study concluded that definitive 'best practice' was unlikely to fit all situations.

The authors' conclusions contribute to the wider philosophical debates about professionalism and teamworking and mental health nursing policy, education, research and practice in general. They are of relevance to a range of individuals interested in multiprofessional working and in mental health care.



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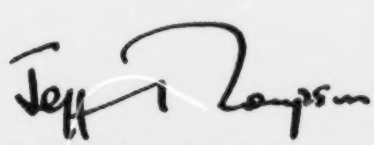

Professor Jeff Thompson
Chair, Research and Development Committee, English National Board for Nursing, Midwifery and Health Visiting

London, 2000

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In 1997, the English National Board for Nursing, Midwifery and Health Visiting (the Board) decided to evaluate pre- and post-registration programmes in mental health in terms of 'effectiveness' in the context of *Health of the Nation* targets for mental health and the implementation of the NHS and Community Care Act 1990 (DoH, 1990). In the project brief the Board stated that the evaluation would focus on the relationship between the discrete role of the mental health nurse (MHN) within the multiprofessional team in a range of care settings and the educational provision for these roles. The extent to which learning outcomes were grounded in relevant education and practice and related research findings had to be evaluated.

1.1 Interpreting the evaluation brief

In this introductory discussion we analyse the sorts of research knowledge and judgement which we felt were implicit in the project. This, in part, provides our rationale for the extension of the original project aims.

Professional practice has two origins:

- job performance, which becomes codified and accumulated as 'experience'
- philosophy, which is translated first into educational procedure and then into professional application.

In the former case, the research task is to find out where effective performance of the job comes from and what tends to prevent it. We start from practice and work our way back to the theories that explicitly, or implicitly, underlie it.

In the latter case, we start from philosophy and trace its translations into educational principle and procedure and then to implementation as professional practice.

This research adopts both these strategies. We focus on the notion of effectiveness; tracing a variety of job performances of the MHN in different work and team contexts and then seek the implicit, or explicit, models of professional practice, as well as the knowledge-use strategies employed by the professional in taking practical decisions. In research terms this is largely an *inductive* approach, based on a form of grounded theory. We also focus on the notion of congruence, i.e. looking at the ways in which philosophies of work are translated into educational prescriptions (curricula and pedagogy) and thence into realisation as professional practice. In research terms, this is mainly a *deductive* process, based on describing and then understanding the processes through which prescription becomes, or fails to become, action.

We seek to address evidence-based and research-based professional practice realistically. This requires an approach to effectiveness and congruence that does not make idealistic assumptions about either the contexts of professional work or about the possibilities of education and training (Stark et al., 2000). Such an approach can be addressed via Jamous and Peloille's notion of the indetermination/technicality ratio (Jamous and Peloille, 1970) in relation to the work of professionals.

- Indetermination refers to ethical aspects, or those based on intuition, practical wisdom, etc.
- Technicality refers to the objective aspects of professional practice that can be expressed as rules or universal procedures.

Jamous and Peloille claim that professional practice usually entails a mixture of both and that there is a tension between the two, whereby managerial outsiders seek to restrict discretion through regulation and professionals seek to retain or extend professional autonomy by emphasising the indeterminate nature of their practice.

The literature highlights that evidence-based professional practice exhibits a continuum from assumptions of high 'technicality' (e.g. Evidence-based Medicine Working Group, 1992; Gyorkos et al., 1994; Barker, 1996; Cook et al., 1996; Gagliardi, 1996; Woolf et al., 1996; Hargreaves, 1997; Murphy, 1997) to assumptions of high 'indetermination' (Humphris and Littlejohns, 1995; Hammersley, 1997; Jacobson et al., 1997). Cautionary voices stress the idiosyncratic nature of work situations, the power of occupational cultures, the micropolitical relation between different levels of staff and different professional groups, as well as the dangers of reductionism. In addition, different models give different weightings to 'cost effectiveness' as opposed to 'excellent practice'. We therefore needed to be alert to the socio-political as well as the technical and to look for indications of effectiveness and explanations for performance in a carefully contextualised way.

1.2 Research design and methodology

Since our research focuses on the notions of 'effectiveness' and 'congruence', we need to have broad initial definitions of these terms.

1.2.1 Effectiveness indicators

We define 'effectiveness' in terms of five effectiveness indicators.

- Perspectival – relating to the perceptions of managers, educationalists, mental health practitioners, other multiprofessional multi-agency team members, mental health students, service users and carers in relation to the contribution of MHNs within the multiprofessional multi-agency team.
- Objective – offering evidence of the audit mechanisms, structures and outcomes of pre-registration mental health nursing in the Common Foundation Programme (CFP), branch programmes of Diploma of Higher Education (DipHE) awards and a range of mental health post-registration programmes and of the realised nature of their intentions within multiprofessional multi-agency teams.
- Interactivity – the research team offers evidence in relation to the *'contributive membership'* (Biott et al., 1997) qualities of the MHN within the multiprofessional multi-agency team. Particular attention was paid to the work of Cowley et al. (1996) on the changing educational needs of MHNs regarding needs assessment and quality of care.
- Predictive – this indicator invited study participants to use their judgement in order to predict likely outcomes and suggest promising future strategies in relation to the development of the contribution of MHNs within the multiprofessional multi-agency team.
- Synthetic – we developed theory grounded in the accumulating survey and case study data, linking it, where appropriate, to pre-existing theory and research in a number of relevant fields, but especially drawing on our experience of educational evaluation, nursing research, mental health nursing and education, the management of innovation and theories of professional development (Stark, 1994; Stronach et al., 1994).

1.2.2 Congruency indicators

We identify three key translation points in relation to congruency.

- The translation of new roles, skill mixes and team-based approaches into educational preparation at pre- and post-registration stages.
- The realisation of these prescriptions as educational practices.
- The congruence of such educational preparation with work performance in real settings both in training and in subsequent professional practice (Norman et al., 1996).

1.3 Research aims

The five research aims are to:

- prepare a documentary analysis of the learning outcomes for mental health nursing in the CFP and branch programme of DipHE awards and in a range of post-registration programmes
- conduct an evaluation of the effectiveness of the application of theory within different practice settings of branch students and practitioners in the context of the mental health nursing contribution within the team
- explore the perceptions of service users and carers in relation to their contribution to programme development
- identify the influences which determine professional performance of the MHN within the team, whether or not training related (such as current work climate, morale, market forces, socio-political forces and so on).
- advise the Board of the implications for educational provision, as well as the development of multiprofessional audit and a linked notion of evidence-based practice.

1.4 Representational strategies and use of language

The team consists of educationalists and MHNs who are also academics, and we acknowledge the influences of assumptions embedded in these backgrounds. We convey our understandings and interpretations of the realities of practice through illustrative examples and quotes. We are careful about the ways in which the concerns of people who use and work in mental health services are represented. This is an important consideration, particularly in view of Foucauldian ideas that the disciplinary practices of psychiatry/mental health are immersed politically in ideologies of definition, categorisation and confinement (Foucault, 1975; Tudor, 1996). We seek to present a text which is politically and morally sensitive in relation to who speaks, how they are positioned, who is silenced and by whom, in terms of the mechanisms of power and privilege (Sparkes, 1995).

We further acknowledge that the use of language is a powerful influence upon the creation and/or maintenance of the care discourses for people who are distressed and need services. We chose, therefore, to use the terms psychiatric nurse/MHN as interchangeable, acknowledging the complexities of assumptions that underpin each term.

Further, according to Miller et al. (1999), the terms multiprofessional, multidisciplinary, interdisciplinary and interprofessional are frequently used interchangeably. However, these definitions are not just technical descriptions. For example, Miller et al. point out that *'multi-skilling'* can be seen as a form of economical *'de-skilling'* (1999: 41) and the *'multi-professional'* role as something that the nurse takes on as the holder of the least defined role (1999: 40). Norman et al. (1998) ascribe different definitions to multiprofessional and interprofessional working, the former tending to relate to health care workers learning similar things and becoming more generic workers, the latter referring to professionals working together to expand the range of skills available in mental health services. Our remit is to evaluate the contribution of the MHN within multiprofessional and multi-agency teams. However, it is sometimes difficult to ascertain how others are using the terms – both within the literature and in the field. For the purpose of this report we have adopted the strategy of Miller et al. that, in general, the terms are being used interchangeably.

2.1 Introduction

Many historical accounts of mental illness services note the appalling neglect and cruelty towards individuals during the three centuries following the Reformation, which led to the reforms of the 19th century and the development of the regulated asylum system (Pavey, 1951; Jones, 1961; Scull, 1979; Jones, 1993). This asylum system was initially constructed around principles of non-medical 'moral treatments'. The approach to care was constructed around normalisation principles which emphasised the achievement of a sense of personal equilibrium for the individual (Wolfensberger, 1970). Over time, this system was taken over by the medical profession and a medical view of mental illness dominated (Manning and Shaw, 1999). As the 19th century progressed, these asylums became overwhelmingly concerned with the provision of custodial rather than therapeutic services. Asylum life was regimented, and passivity and dependence induced among the population. The ultimate symbol of the desire for efficient control was the *'panopticon'*, invented by Jeremy Bentham in 1843 (Manning and Shaw, 1999). This was an institutional environment where one person could simultaneously maintain surveillance of a large number of the asylum's patients – in Foucault's terms (1975), extending the *'gaze'* of the observer.

Modern mental illness services have come a long way since these early beginnings. Services that were once typified by singularity and fragmentation have been transformed into more pluralistic and integrated approaches, where the 'gaze' (albeit of some rhetorical vista) is now shared across a wide group of professionals and non-professionals alike (Pilgrim and May, 1998). Through this review of the literature we are able to develop our own 'gaze' of what we consider to be a 'turbulent' context in the development of mental health care. We explore how the emerging discourses of collaboration and partnership between health care professionals impact upon the practice and educational experience of MHNs.

2.2 Policy context

Our starting point is to develop an understanding of what policy *is* in the context of mental health policy development in the UK, and to do this several interrelated macro, meso and micro factors need to be taken into account (Mohan, 1996):

- at the macro level, national strategic objectives and guidance on policy and practice for mental health professionals and, in the context of this study, the development of collaborative rather than competitive working practices
- at the meso level, how these policy objectives are given a form and structure as the mental health care environment and, in the context of this study, the development of new organisational forms with more permeable boundaries which promote partnership
- at the micro level, how the actions of individuals transform policy into 'everyday' practice, and in the context of this study, how individuals experience multiprofessional practice.

Thus, we argue that policy does not just consist of national strategic documents, such as the periodic governmental White Papers published as frameworks for reform and/or modernisation in the provision of public sector services (Warne, 1999), or in how managers, practitioners and educationalists implement these. It also involves the actual practices grounded in day-to-day work in health care and educational settings. It is therefore important when considering policy to view how and why the policy was developed and subsequently translated and implemented *and* to consider policy making as the *outcome* of the process of implementation (Allsop, 1984). In addition, we have tried to stress that the kinds of *'couplings'* (Cuban, 1990)

that link the levels is crucial to the understanding of how policy is implemented, resisted and adapted through the process of translation and implementation.

2.2.1 The background to UK mental health policy formulation

In the UK, at any one time, around one in six adults will have some form of mental health problem, although less than 1% of the population suffers from a severe mental illness (DoH, 1998). Misunderstandings about these problems are common and often stem from a complex aetiology of opposing beliefs and stigmatisations arising from fear, condemnation and guilt (Philo et al., 1994). Over time, understanding of mental illness has moved from the sacred and magical to the bio-scientific and medical (Foucault, 1975) and to the secular and anti-psychiatry movements (Rogers and Pilgrim, 1997). These were responses marked by movements from high community status of individuals or groups seen to be vulnerable, dependent and/or deviant, to concealment and confinement in institutions and, latterly, to community *'reintegration'* (Porter, 1990; McCourt Perring, 1997). Historical developments of mental health policy in response to these factors have been well documented (Jodelet, 1991; Jones 1993; Rogers and Pilgrim, 1996; 1997). Such shifts have involved medical care, social care and the criminal justice system (Szasz, 1971; Handy, 1995). However, the increase in the number of professional groups and agencies has not always been matched by congruent levels of multiprofessional working.

2.2.2 Service revolutions

Previous Government administrations were (and current administrations are) caught on the horns of a policy implementation dilemma: how to handle the apparent failure of care in the community without recourse to the socially and economically unacceptable large and remote institutions (Ford and Ryan, 1997; McCulloch and Boxer, 1997; Shepherd, 1998). There have been a number of well-publicised hospital scandals that have added impetus to developing community-based services (Martin, 1985). Since the early 1950s, anti-institutional and de-hospitalisation movements have succeeded in achieving a downward trend in the number of individuals in hospital. Conversely, more recently, community care has been said to have failed (Dobson, 1998). Underpinning this policy dilemma are three interrelated factors that have their origins in the three *'revolutions of service provision'* (Jones, 1975; 1993). These revolutions relate to the introduction of new forms of medication (in particular the use of chlorpromazine); the development of a wider range of services (day hospitals, hostels) and the legal reforms brought about by the 1959 Mental Health Act. These 'revolutions' spawned considerable debate over the relationship between mental health and social order, and the movement from legislative legitimacy to medicalised normality (Goffman, 1958; Foucault, 1975; Scull, 1979; Rogers and Pilgrim, 1997; McFadyen et al., 1998). This debate has given rise to a great deal of turbulence and a number of tensions that, we suggest, are likely to inhibit multiprofessional and multi-agency working.

At the meso and micro level there is a sense of tension caused through non-oppressive clinical practice, in which the rights and wishes of the individual are respected, while trying to ensure the protection of the wider community (Dear and Taylor, 1982; Jones, 1993; Huxley, 1995; DoH, 1998; Burns and Priebe, 1999). These studies note the tension involved in maintaining professional standards of practice in a changing environment characterised by paradoxical economic concerns of efficiency, set alongside a wider societal and political concern for safety and containment. While some members of the multiprofessional team can deal more easily with these tensions (McKee et al., 1997; Warne, 1999), this is not the case with MHNs, who are being asked to do more with less (Powell, 1999). They lack, for example, the professional power medical team members have and this brings into sharp relief the negative effect of trying to maintain professional standards when resources are reduced or refocused. It has been noted, for example, that where individual service users fail to receive consistently high quality services, this can contribute to the deterioration in service users' wellbeing, heightened societal isolation

and increased risk of harm to themselves or others (Prins, 1996; Ryan, 1996; Reed, 1997; Raven and Rix, 1999).

Connected to this tension is the way in which society has not significantly altered its attitude toward and prejudice against the mentally ill (Pavey, 1951; Calnan, 1987; HEA, 1997), for example, the persistent connection made by the public between violence and mental illness (Dear and Taylor, 1982; Philo et al., 1994; Ryan, 1996). While there is a sub-group of individuals with a mental illness who are violent, mental illness and mental health continue to be portrayed in the media as being abnormal, frightening and stigmatising (Noble and Rodger, 1989; Pilgrim and Rogers, 1999). As a consequence, concern has arisen regarding the avoidance of oppressive approaches to professional practice which has spawned an industry concerned with risk assessment and risk management (Gunn, 1990; Harrison, 1997; Raven and Rix, 1999). We felt this issue should be further explored through an examination of how different teams and agencies worked with the Care Programme Approach (CPA – a multiprofessional and multi-agency activity central to the achievement of current policy objectives in England). The use of the CPA is based upon legal processes and the literature notes tensions in how individuals within different professional groups interpret and respond to the appropriate legislative powers for clinicians and practitioners (Ramon 1986; Sjostrom, 1997). In particular, concern has been expressed over the development of *'community supervision orders'* (Machin and Stevenson, 1997). MHNs, particularly those working in the community, have viewed increasing control and supervision of individuals with a mental illness as being undesirable and incompatible with the role which mental health nursing perceives for itself (McFadyen and Farrington, 1997).

While there is an issue over the power relationship that might exist between the MHN and the service user (Bowers, 1992; Coleman, 1996; Barker et al., 1999), the issue is also significant in terms of establishing the boundaries of professional practice and professional interventions (Ramos, 1992). The legal frameworks can both determine and be determined by clinical practice (Newdick, 1996). However, the development of legal frameworks has often been a piecemeal process. The consequence for service users and providers has been either increased or decreased effectiveness in multidisciplinary and multi-agency working (DoH, 1999b).

2.3 Mental health law

It appears that the legislative underpinning of many of the current policies is the provision of hospital-based, secondary services and not in the wider development of primary care or community-based services (Brindle, 1998; Girvin, 1998). In this sense, the law has been more concerned with addressing issues of resource allocation than with individual rights (Newdick, 1996). This has significant implications for mental health nursing and the implementation of the current policy promoting multiprofessional and multi-agency working. Prevailing mental health law focuses on the compulsory assessment and treatment of service users in hospital. Clearly, contemporary approaches to mental health care encompass many non-institutional approaches. However, MHNs and other mental health professionals are still educated primarily to practise within this legal framework.

In September 1998 Professor Richardson was appointed to review the prevailing mental health legislation in England and Wales. A year later the Green Paper, *Reform of the Mental Health Act 1983*, was published (DoH, 1999b). This sets out a wide range of proposals ensuring that the underpinning legislative base for mental health practice reflects evidence-based practice (clinical and legal), and supports the modernisation process of achieving greater secondary and primary care integration. The proposed Act will fall under the statutory duty for agencies with responsibilities under the Act to work together. This element of a 'statutory duty' to work together is important but possibly not realisable in practice (Warne, 1999).

At a rhetorical level this Green Paper and other recent health and social care policy changes connect back to the White Paper: *The New NHS: Modern, dependable* (DoH, 1997a).

It can be argued that the current mental health policy initiatives are more clearly integrated with other social policy objectives than previous approaches. This integrative approach has been further developed in the National Service Framework (NSF) for Mental Health Services (DoH, 1999a) in the development of service models and standards.

The policy agenda of multiprofessional multi-agency working in the context of both mental and general health and social care is clearly articulated throughout these policy statements. This agenda rekindles the debate over shared understandings of mental health and/or illness terminology in relation to the formulation or implementation of policy (Tilley et al., 1999).

2.4 New structural forms

The movement from services centred in hospitals to services in the community has been a visible outcome of mental health policy initiatives over the last two decades (Manning and Shaw, 1999). Given that this movement has largely been determined at a meso level, by health and social service authorities (since they are responsible for purchasing and/or commissioning mental health service), there is some doubt as to whether the actual reprovision of services in the community has matched the rate of bed closures in hospitals (Goodwin, 1997). Both health and social service authorities have been unable to invest in the comprehensive development of community-based facilities due to continued financial pressures, which has resulted in a greater share of service provision being undertaken by providers from the independent sector (Evandrou and Falkingham, 1998).

In the context of a more integrated approach to health and social care, the Government has introduced the concept of a single body that can eventually determine the objectives of both the assessment and commissioning of health services for a defined population. Primary care groups (PCGs), which will become primary care trusts (PCTs), are the organisational form and potential change agents for implementing the NHS modernisation programme. They have responsibility for the commissioning of general health care for populations of 55,000-220,000 and will, in some circumstances, be able to make more efficient use of resources through the bringing together of health and social care budgets. The policy emphasis is on achieving national priorities through locally sensitive programmes. Understanding what the local health needs might be is the first step in this process (Shanks and Khera, 1995). We feel that, at the micro level, many community psychiatric nurses (CPNs) will be able to effectively contribute to this process since many of them have an extraordinary sense of the *'community'* (Skidmore, 1997) within which they work.

2.4.1 Service users gain a voice?

Since the mid-1970s, health care policy in the UK has increasingly recognised the importance of involving the service user and carer in all aspects of service planning, delivery and evaluation. Currently, user involvement is the *'ideal'* in the provision of mental health care (Campbell, 1996). The NSF (DoH, 1999a) is a good example of current policy which explicitly states that users and carers must be consulted. Such involvement will change the role of the individual from passive recipient to active and influential participant in the achievement of physical and mental wellbeing (Ledwith, 1999).

There is some evidence, however, that many services are constructed not to meet the users' needs, as articulated by the users, but within professionally constructed paradigms (Opie, 1997; Gittins, 1998; Middleton and Shaw, 1999). Thus, many service users do not believe the representative services represent their position, and user involvement in policy and/or service planning does not guarantee a good, or appropriate, service for any particular target group (Van Hoorn, 1992). Many users dislike the dichotomy of service foci, reinforced in current policy guidance, which over-simplifies their lives onto a poorly defined framework of severe and enduring mental illness (SEMI) (Coleman, 1996) or the disparaging 'worried well'. In nearly all circumstances SEMI will correspond to a diagnosis of schizophrenia or bi-polar mood disorder,

and, even though implied rather than stated, the term *'psychotic'* being preferred (Onyett 1997; Norman et al., 1998). Many users preferred to see mental health as distress experienced by the individual which could be best measured along an idiosyncratic continuum of felt experience (Coleman, 1996). Barker et al. (1998) agree with Coleman (1996) that a holistically conceptualised mental health service based on *need* not *diagnosis* should be the aim. It appears that many service users are not afraid of their diagnostic titles and that mental health service providers have more of a problem in using terms such as schizophrenic, often fudging the issue by using an indistinct and largely irrelevant catch-all term such as SEMI. This reflects a professional debate where the knowledge upon which practice is based incorporates the values, work ethics and attitudes represented by the collective ethnocenticism of the various professionals (Nyatanga, 1998); the most dominant of which, even in the more egalitarian mental health care team, remains the medical profession (Mohr, 1995; Barker et al., 1998; Simpson, 1999).

Waterworth and Luker (1990) have discussed how users may be reluctant to work collaboratively with practitioners, preferring to 'toe the line' and do what the professionals say. Ramos (1992) considers the differences in people's needs for *'connectedness'*. She highlights the potential for inappropriate over-involvement as an ever-present possibility, as well as difficulties inherent in developing therapeutic relationships. There is, of course, the notion of empowerment which implies that users want to take responsibility for their condition or at least have some say in treatment. Skidmore (1994a) argues that this is not necessarily the case and that some comfort/security can be obtained from handing on the problem for others to deal with. It is clear that achieving greater user involvement is potentially fraught with difficulties. Such issues surrounding service user involvement will be revisited throughout this report.

2.4.2 Developing services

The organisational, professional and economic problems involved in developing services that transcend the existing boundaries and structures of independent organisations, have been well documented (Haywood and Alaszewski 1980; Soni et al., 1989; Alter and Hage, 1993; Klein, 1995; Corrigan and Garman, 1999; Miller et al., 1999; Warne 1999). Many of these studies have indicated a range of generic problems involving communication difficulties, a lack of effective team management, leadership conflicts and poor role identification. In relation to mental health nursing practice, Norman et al. (1996) noted that a polarised range of perceptions exists in the view of MHNs that illustrated these difficulties. One view was that the MHN should maintain clear professional boundaries with strong professional managerial structures and support, separate from other workers in order to avoid becoming a 'jack of all trades'. The opposing view was that MHNs should develop an allegiance with other community workers (particularly nurses) and be managed in a structure that incorporates all professional groups. Neither approach, in isolation, may result in greater multidisciplinary working or a movement from a service-led to a needs-led approach. In addition, if one profession has more *'permeable'* boundaries than another, then it may be vulnerable to the predation of other professional groups (Leana, 1987). Overlapping areas of work are likely to be absorbed by the more powerful professional group (Corrigan and Garman, 1999). We believe that as PCGs and PCTs continue to develop, these multiprofessional issues will require closer examination. The effectiveness of service infrastructures can be reduced through such difficulties, making the need for effective multi-agency working more significant.

2.5 The mixed economy of care

The economic drivers for policy development are revealed in their use to effect alternative forms of social control. The shift from hospital- to community-based services has, possibly, resulted in cost savings, not because it is cheaper to provide community care but rather the quality of care has been lowered and true service integration seldom achieved (Walker, 1982; Mohan, 1996; Goodwin, 1997). In the context of mental health services, multi-agency integration has a long history in both theoretical approaches and practical application (Manning

and Shaw, 1999). Integration may not have been effected perhaps due to the often independent approaches of many of society's agencies in responding to isolated and individual social factors as they are experienced (Soothill et al., 1995). Perhaps, in recognition of this, current policy is constructed around a *discourse* of collaboration and partnership.

The factors in Figure 2.1 offer a template for a 'network' organisation capable of delivering effective responses to mental illness which will require multiprofessional, interprofessional and multi-agency teamworking (Leiba, 1997; Burns and Priebe, 1999; DoH, 1999a).

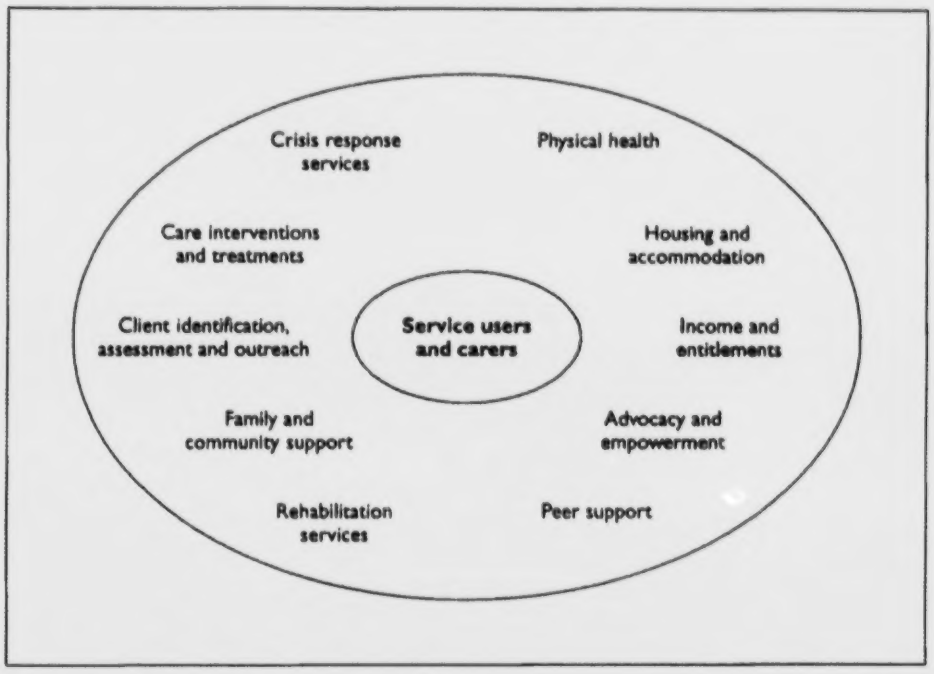

Figure 2.1: Factors likely to be found in comprehensive and integrative mental health services (Adapted from NHS North West Executive, 1999)

We note that such factors, however, have been used more often to determine the distribution of resources for mental health services (usually in the form of support for a given number of beds per head of population) than in the development of comprehensive services (Glover et al., 1998). This latter approach represents an ideal that acknowledges, but only in passing, the huge differentials in gate-keeping powers, professional boundaries, time frames, public accountability and the diverse organisational cultures of the various players involved (Ledwith, 1999). We believe these two different approaches have implications for how agencies might perceive each other in a genuine desire to work towards multiprofessional multi-agency working. It is noticeable that the pictorial representation of this model is a metapolitical realisation of 'holism'. The user is central, cocooned by a further circle of freely available services and ideals.

2.6 Strategic direction

Although it could be argued that the NSF (DoH, 1999a) is an effective example of integrative or joined-up policy formulation (Simpson, 1999) we believe that, in adoption, it perhaps further illustrates a policy implementation process that is highly centralised (Light, 1998; Powell, 1999). For example, the NSF prescribes a series of national standards upon which service models should be developed, and these standards are said to be realistic, challenging and measurable and to be based on the best available evidence (DoH, 1999a). We feel that the

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implications of this somewhat contradictory and centralised guidance, where local initiatives are to be encouraged as long as they meet national imperatives, may force different agencies into developing largely rhetorical strategic development plans, devoid of any useful objective setting. As such, it is unlikely that this framework will halt the 'strategic drift' of policy implementation, said to have been exacerbated by the introduction of the internal market and provider/purchaser split (White, 1990; Beese and Turnbull, 1996; McFadyen, 1997). For example, as has been noted above, the object of policy setting, within mental health, has been to focus on those individuals with a SEMI problem. In relation to MHNs, the *Mental Health Nursing Review* (DoH, 1994) made 41 recommendations for changes in mental health nursing to support the policy objective of targeting services to those individuals with a SEMI; yet, five years later, it is still possible to discover that many CPNs, for example, continue to work with those who do not have a SEMI (Middleton and Shaw, 1999).

It can be argued that, within mental health policy development, economic considerations have generally provided the greatest impetus for either driving or resisting change (Scull, 1979; Himmelman, 1996; Pilgrim and Rogers 1999). Purchasing has been relegated to a technical component of the more important (and considered) commissioning of services. However, we note with interest that the language of current policy guidance still refers to such notions as *'economical viability'*, *'influence and leverage'*, *'income size'*, *'risk to budgets of fluctuations in high cost/low volume work'* and *'political and economical clout'* (DoH, 1999a; NHSE, 1999; Warne, 1999). This language, perhaps, belies the rhetorical nature of the wider policy objective of dismantling the health care market and the Government's commitment to greater collaborative working.

While reciprocity has long been the dominant feature of many community and social care service provisions (Oliver, 1990; Warne, 1999), this has not generally been the case in relationships between these and secondary health care services. This is a consequence of the different professional and management approaches of these service providers (Soothill et al., 1995). For example, different health care professions may exhibit 'tribe-like' behaviour, as well as the strong sense of resistance to innovation often found in professionally dominated organisations (Beattie, 1995; Cole and Perides, 1995). Beresford and Trevillion (1996) note that often such collaborative working in the community is about achieving empowerment and collective action between professionals and clients. In the context of mental health care such transformations have provided limited evidence of good practice. An examination of these factors formed part of the enquiries made through the survey and case study visits.

2.7 Counting the cost of community care

In the past, several policy objectives relating to more effective community care were not adequately funded, with communities and professionals being expected to do more with less (Himmelman, 1996; Knapp et al., 1999). Likewise, many of these policy objectives have been subject to confusing or overlapping guidance, poor performance management and project control (Leff, 1997; Corrigan and Garman, 1999). These factors were noted as being avoidable elements in the care of Christopher Clunis, who suffered from paranoid schizophrenia and attacked and killed a stranger (Ritchie et al., 1994; Raven and Rix, 1999). This case highlighted the shortcomings of a policy that was not enacted or implemented in a coherent fashion by practitioners working across a wide range of different agencies. The report into the tragedy noted a lack of professional liaison, a poorly understood and implemented CPA, a limited range of appropriate facilities in health and local authority sectors and a range of difficulties inherent in trying to provide long-term care and support to those with a SEMI problem (Ritchie et al., 1994). Although this was a high profile case of multiprofessional multi-agency failures, it is not unreasonable to contemplate a situation where many practitioner communities commonly fail in such ways (Knapp et al., 1999; Raven and Rix, 1999).

Support for this view can be found in the report *Finding a Place* (Audit Commission, 1994). This report critically appraised service provision and its underpinning policy. For example, it noted the imbalance in spending, where two-thirds of the resources spent on mental health went to support inpatient services, yet there was empirical evidence to suggest that more efficient community-based assessments and treatment were cost effective (Müijen et al., 1992; Tyrer et al., 1998). This report pointed, again, to policy being provider driven, rather than needs led. It also brought into sharp relief the need to develop policy guidance that addressed how an integrated approach, involving meeting the holistic needs of both the user and the professional care givers, could be achieved. We believe there are a number of reasons why this policy objective might be difficult to achieve. For example, the economic policy objective of 'achieving more with less' appears to be experienced more keenly on acute admission wards with higher numbers of patients presenting with high levels of dependency (Knapp et al., 1999). However, operating the inpatient areas in this way is highly dependent upon effective and responsive community services being accessible, through planned integration (Chan and Rudman, 1998).

It could be argued that the policy objective of bringing together separate organisations into a 'network' should reduce the negative impact of the different cultural and organisational elements currently encountered (Corrigan and Garman, 1999). However, current policy guidance encourages the formation of specialist mental health trusts as the preferred model of professional practice provision (DoH, 1999a). How these new trusts will relate to PCGs and the wider network of organisations remains complex (Doyle, 1998; Wilson, 1998).

PCGs/PCTs will need to liaise with a vast array of different agencies capable of providing both generic and specialist mental health services. Thus, achieving fully integrated services will require the adoption of extremely flexible approaches (Moss-Kanter, 1990; Duggan, 1997; Doyle, 1998; Corrigan and Garman, 1999). It is clear, however, that organisational structures often inhibit the promotion of such thinking. Flexibility remains an externally realised phenomenon rather than an internally generated form of social action (Peters, 1995; Warne et al., 1999). The movement from hospital to community care, which often involved services being transferred and provided by existing staff, suffered from this inability of many staff to re-focus and create a new organisational culture (White, 1993). We note that bringing individual health care professionals together, in a particular setting with a particular focus for practice such as in the case of multiprofessional teams, does not, in itself, ensure effective service provision (Soni et al., 1989; Stacey, 1996). Indeed, Norman et al. (1998) claim that evidence is scarce in relation to the benefits of interdisciplinary working for service users.

2.8 Practice environments

Following on from the broad contextual perspective at the policy level, we examine the literature relating to the actual practice of mental health care. We explore those issues that can potentially influence the practitioner in the delivery of their role; how culture, environment and socialisation can exert an effect on a practitioner joining a team and, subsequently, the influence of relationships and team power.

2.8.1 Culture

We suggested earlier that the practice of mental health care is, to a large extent, institutionalised in the sociological sense of the word. The problems that this creates for mental health care delivery have been widely discussed (Hunter, 1960; Altschul, 1973; Golan, 1978; Butterworth and Skidmore, 1981; Bowers, 1994). History, therefore, tends to dictate the type of care offered. Dietrich (1978), in describing the teaching of psychiatric nursing in the classroom, places custodial skills as those that are highly visible, whereas Morrall (1998) points to psychiatric nursing as being subordinate to psychiatry and still enmeshed in the social control function; therapy, as such, lags behind in importance. Porter (1993) contends that MHNs do not interact therapeutically with clients, they *constrain*: the MHN is always in a more powerful position than the client and the power in such a situation is always coercive. Glenister (1997) points to

coercion and control being central to MHN practice and claims that the therapeutic dimension to nursing is taken for granted, while the social control aspect is ignored. Barker (1990) has asserted that mental health nursing still functions mainly as a medical support system, albeit while attempting to ground its own practice in the broader churches of interpersonal skills (Peplau, 1987; Burnard, 1989), psychosocial orientations (Butterworth, 1987; Adams, 1991) and reference to the possibility of a specific mental health nursing paradigm (Adams, 1991).

When the deinstitutionalisation programme commenced, a major problem for MHNs was that they were cultured into responding to sickness during the days of the large mental hospitals and have been gradually expected to respond to health issues with the growth of community care (Rivett, 1998). During and following pre-registration education, practice seems to develop according to the contexts within which nurses find themselves. Thus, in addition to curricular content, philosophical and pedagogical approaches and the ultimate effectiveness (or otherwise) of formal and informal clinical education, mental health nursing could be said to be a product of the needs and culture of the clinical environment. We found that self-protection is a pervasive and recurrent theme for MHNs and other practitioners within this study and this concept will be revisited in order to illustrate the theme of nurses' defensiveness and 'survival by camouflage' – sometimes becoming almost invisible members of the team in their adaptation, or sometimes wholeheartedly embracing the expectations of the team, in order to survive.

2.8.2 Generic, specialist or just blurred?

For many MHNs, as well as other health care professionals, there are difficulties with the ways nursing is articulated. There is an almost 'taken-for-grantedness' that assumes everyone 'knows' what nurses do. The inability to articulate one's role could prove to be a barrier to effective multiprofessional teamwork.

Earlier in this report we suggested that the notion of indeterminacy, as put forward by Jamous and Peloille (1970) in their *'indeterminacy/technicality ratio'*, has been a useful way to explore facets of this study. For example, it contrasts such areas as the MHN's ethical practice, intuition and personal ways of knowing, with more technical, 'skills' issues. Furthering this debate, mental health nursing work can be perceived to be 'generalist', something Gijbels (1995) explored within acute mental health care settings. His findings suggested that nurses were perceived by other members of the health care team as 'jacks of all trades', good at dealing with the messy realities of everyday practice but not having 'specialist skills'. There was the additional notion that nurses often could not use specialist skills with people, because of time/resource issues. The consequences of the current mental health arena and multiprofessional teamworking present tensions for the MHN. The use of specialist skills as a self-preservation strategy, linked to notions of professional boundaries and protectiveness of roles, has been explored as a perennially relevant issue (Skidmore, 1994a).

2.8.3 Socialisation and 'being accepted'

The impact of the practice environment upon the professional socialisation and practice of student nurses is well-established (Ogier, 1981; Fretwell, 1987; Melia, 1987). Fitzpatrick et al. (1996) note influential environmental factors to include the accessibility and approachability of trained staff, sensitivity to the learner's needs, the power of role models, the philosophy and management styles of the ward sister and so on. The implications of socialisation for learning effective multiprofessional teamwork within mental health settings, therefore, cannot be underestimated.

Normally, because of its institutional nature, practitioners *enter* a team rather than becoming part of it. They have to negotiate membership or be socialised into the culture; such a process involves social exchange which may demand conforming to a group norm. Quinn (1988) highlights the complexities inherent in *'becoming an effective team member'* especially when allegiances to the shared values of the team may be contradictory to specific professional

identities – does one serve the interests of the client or be loyal to the team? Merton (1957) defined the socialisation process as: *'the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short, the culture – current in groups to which they are, or seek to become, a member'* (1957: 278). The understanding of attitudes, beliefs and values appropriate to a particular profession are viewed as central to the adopting of a particular occupational role. These issues will be revisited later in the report.

Nolan (1993) discusses how different professional groups have different beliefs about what others do and this can have a particular bearing upon how practitioners work together. These findings are similar to those of Miller et al. (1999) and Norman et al. (1998). Lacey (1977) proposed that an individual's past experiences also impinge upon the socialisation process, with the individual's personal qualities, values and motivations also being intrinsic to the socialisation process (Du Toit, 1995). Further, in considering how team members 'become accepted' it seems that prior experiences were crucial, as were individual investments in the team. This can lead to tribalism and/or escapism, that is seeking solidarity with like-minded practitioners or hiding behind a specialist skill.

Additionally, the ethical principles and moral values underpinning policy (and the law) and professional practice also have significant influences upon multiprofessional teamwork practice. For example, MHNs are bound by the UKCC Code of Professional Conduct (1992), occupational therapists (OTs) have their Rules of Professional Conduct for Occupational Therapists and psychiatrists are required to practise according to British Medical Association Guidelines. Additionally, all are required to fulfil the requirements of the Mental Health Act Code of Practice (DoH, 1997b).

Fitzpatrick et al. (1996) suggested that individuals also perceive their identity in relation to those who have related roles (role models). Indeed, research has explored the influence of peers on the professional socialisation process (Oleson and Whittaker, 1968; Jacka and Lewin, 1987; Iwasiw and Goldenberg, 1993), for example, the impact of the psychological model on mental health nursing by way of cognitive and behavioural psychotherapy and subsequent 'nurse therapists'. This would seem to have considerable implications for teamwork, when 'peers' could be from either the same practice discipline or different professions, with all of the allegiance and identity issues this entails. Role models will be revisited in Chapter 9 of this report. Further, Mohr's (1995) suggestion, that the language of mental health care be subjected to intense scrutiny, exploring underlying assumptions and inadequacies, is something we would endorse. In addition, controlling categories, such as diagnostic labelling and prognostications by key team members, need questioning. The nurturing and valuing of difference and heterogeneity of thought within teams, by way of searching for *'fruitful interpretations'* (Flax, 1990), is a further strategy which could enable insightful education for MHNs and other professionals, as could focusing on (rather than accepting and ignoring) undecidables and paradoxes.

Opie's (1997) focus upon the representational practices of health care teams, with regard to clients, and how these practices make an impact upon teamwork, is also worth considering. In addition to offering some tentative conclusions about some of the conditions required for effective team processes, she also emphasises the importance of the commitment of organisational resources to the development of teamwork. In order to move beyond the familiarity of everyday practical actions, in the face of resource difficulties, we would endorse her view that awareness is required of discourses spoken by different members of the team. The fostering of reflexive teamwork, which she is suggesting, requires the nurturing organisational environment suggested by Webb and Hobdell (1980) and Miller (1993); together with notions of *'common purpose, separate skills or professional contributions, and some process of communication, co-ordination, co-operation, or joint thinking'* (Kane, quoted in Sands 1993: 546).

2.9 Multiprofessional teams

The momentum for multiprofessional teams has grown since the 1970s with many community mental health centres (CMHCs) being built to provide these services closer to the communities they served (Opie, 1997). The development of multiprofessional teams, as the preferred model of service delivery in mental health, has been relatively consistent in the UK. Meuser et al. (1998) argue, however, that the actual make-up of teams developed on an *ad hoc* basis rather than through planning and responding to service user needs. Consequently, one might expect there to be no standard template of a mental health team and, therefore, a marked variation to exist throughout the regions. As noted earlier, however, regardless of membership, the focus of intervention is often dictated by the 'strongest' practitioner, although the success of such teams has not always been easy to discern (Paxton, 1995; Onyett and Ford, 1996). There appears to be a multitude of *internally* and *externally* generated problems that inhibit effective and integrative multiprofessional and multi-agency working (Øvretveit, 1995; Corrigan and Garman, 1999; Miller et al., 1999). These problems are well known and can often be seen in partnership arrangements across public and private sector organisations (Senge, 1990; Stacey, 1996; Miller et al., 1999). Such problems include:

- the lack of a coherent and shared vision (Ansoff, 1990)
- the maintenance of independent support systems for information gathering and dissemination (Dyer, 1995), leading to ineffective communication (Charan, 1991) and failure to achieve an effective balance between strategic and operational management (Pettigrew and Whipp, 1992)
- a lack of agreement about what working together means (Norman et al. 1998)
- nominal understanding or appreciation of the roles of others (Peck and Norman, 1999)
- collaboration not automatically generating a knowledge of the roles of others, or a protection of professional boundaries (Miller et al., 1999).

In addition to these factors and specifically within the context of mental health teams, we note other factors which inhibit effective teamworking and multi-agency collaboration. Kavenaugh (1988) and Rhodes (1991) have put forward the notion that psychiatric care settings are frequently fraught with uncertainty and require the management of irrationality in the face of chaotic organisational environments. This would echo our own findings, discussed in subsequent chapters, where the nature of acute settings is unpredictable and management is frequently accused of poor communication and being out of touch with the workforce. Further factors, militating against effective teamworking in mental health, include the major protagonists coming from diverse backgrounds, the independent pursuit of professional interests, hierarchical, organisational and professional arrangements, single professional training and preparation for practice and different ideological foci (Dyer, 1995; Paxton, 1995; Kotter, 1997; Doyle, 1998; Hibberd, 1998; Norman et al. 1998; Corrigan and Garman, 1999). Indeed, Bergen et al. (1996), when looking at community nurses, found that the central component of the 1990 Community Care Act – the joint assessment – became the least experienced activity for nurses in practice and so collaboration remained at an ideological level.

Such difficulties in teamworking can also be seen in single professional groups. For example, in the case of the MHN, re-evaluation of the role boundaries working in both secondary and primary care settings, or role boundaries within existing organisational forms (Turner, 1990; Tudor, 1996; DoH, 1998; Ledwith, 1999) has seldom been undertaken. We believe the implication of this might result in a theory-reality gap between policy and its implementation, and a practice-practice gap between mental health practitioners in different care settings. This may, in part, be due to the changing nature of the case-mix in different settings. For example, individuals are increasingly being discharged much earlier from acute admission wards, thereby devolving more care onto community nurses (Jones and Kamath, 1998). Similarly, as little as

10 years ago, there might have been only a handful of patients who required high-level care on a 25-bedded ward – now there may be 25 patients requiring high-level care. Many inpatient services consistently operate at levels of 80%-120% bed occupancy (Ford et al., 1998). Managing such situations requires effective leadership and managerial skill (Corrigan and Garman, 1999). In many instances, the consultant psychiatrist has provided such leadership, although this has typically been of a benign nature (Soni et al., 1989). It appears that to some extent, the medical profession at the primary and secondary care level has taken a more egalitarian approach to concepts such as teamworking and multiprofessional approaches to mental health care than their colleagues in acute medicine (Nolan, 1993). This may well have been a response to the sustained challenges to institutional psychiatry evident in the work of Goffman, Szasz and Laing during the early 1980s (Hopton and Glenister, 1996) or, as in some paternalistic gesture, *'the giving away of power'* as a form of gift exchange (Warne, 1999). However, the dwindling numbers of consultant psychiatrists need to be borne in mind. It may be that individuals have 'given up' some aspects of their leadership role because of stress and an organisational agenda that militates against the development of a clinical or professional focus (Handy, 1975; Bass, 1990; Corrigan et al., 1995; Onyett et al., 1997).

The literature suggests that where such leadership is available (not necessarily provided by the consultant psychiatrist), a number of key features of teamworking are evident (Corrigan and Garman, 1999). These include the work of team members involving face-to-face interactions (Dyer, 1995), and individual members of the team mutually influencing each other (i.e. the direction of their efforts is not determined by one individual but through participative decision-making processes (Soothill et al., 1995)). The success of the team's activities results from interdependent action across the team (Dyer, 1995), individuals perceive themselves to be members of the team, and this sense of belonging is closely linked to the focus of the teams efforts (Handy, 1995). There is also a shared understanding of the team's goals and objectives that is reflected in the team's range of activities and tasks (Oliver, 1990). Corrigan and Garman, (1999) note that the effectiveness of teamworking measured against these criteria is largely the result of effective team leadership. Such team leadership is more than the rhetorical leadership often associated with positional and expert power-based organisational authority (Vroom and Yetton, 1973; Handy, 1995; Stacey, 1996; Robinson, 1998).

Although the work of Corrigan and Garman (1999) looked at the multiprofessional team in a single organisational structure, we believe that the need for strategic leadership across different organisational configurations is equally essential. As noted above, there is a great deal of difference between having a statutory duty for partnership working and this duty actually being realised. Current policy objectives reinforce the taken-for-granted need for more collaboration in the provision of mental health services (Ledwith, 1999). However, Provan and Millward (1995) have noted that despite this strong drive towards integrated service provision, there is little empirical evidence to support the presumed relationship between integration and achieving effectiveness across a network of service provision that encompasses those factors noted in Figure 2.1. One group often excluded from this network are the service users themselves (McDougal, 1997).

2.9.1 Team power

It has been recognised for some time that therapeutic power offers security to the practitioner: the operation was a success but the patient died (Miller, 1978). The whole arena of therapeutic intervention leads the therapist into a symptom focus and a response to that symptom rather than the problem described by the client. The obvious danger here is that the client can fall into the category of being incurable merely because his symptoms have been pre-defined. Skidmore (1994b) illustrates how the 'team's goal' often proves problematic for the client, when all the client's problems are viewed in relation to a specific therapeutic approach. This notion of therapeutic misunderstanding is not new. Roth (1963) illustrated the effect of therapeutic power on the service user because of the professional's application of 'timetables'

based on diagnosis. In turn, this led users to 'feeling' that their condition was 'worse' than their contemporaries, since they had no knowledge that professionals were constantly renegotiating 'timetables' in response to new knowledge (indirect influence). In addition, one could argue that the type of intervention a service user is offered is a lottery; it really depends on where they are and which practitioner has the most 'clout' in leading the team.

Related to the issue of power is identity. Indeed, often what one does is seen to be more important than who one is. This is crucial when we witness how multidisciplinary teams (MDTs) perform. Many of the teams observed in this study felt that they were dominated by medics, consequently responding to perceived symptoms.

2.9.2 Partnerships with users and the voluntary sector

It appears that the perceptions of service professionals, policy planners and service users lack congruency in relation to mental health care. It is argued the user should be the service provider's *raison d'être*. However, this somewhat simple assertion belies a long history characterised by a quite different view of the role and response of services to users accessing them. Unfortunately, many health care organisations have been service led rather than needs led (Klein, 1995), despite the rhetoric espoused in policy documents (DoH, 1994; DoH, 1999a).

Since the 1970s, policy has been aimed at developing more integrated services for those individuals with a SEMI and, consequently, many service providers have organised their resources around multiprofessional teams (Tudor, 1996). However, much of the work undertaken in examining the effectiveness of these teams has not addressed the role of the voluntary sector or the service users themselves in promoting good mental health. If these groups and individuals were paid an hourly rate, commensurate with the national minimum wage, their care would cost in excess of 10 times that of professionally provided care (Nolan et al., 1996).

Users of mental health services, however, have not been able to take advantage of the changes to the organisational structures and, from a social and cultural perspective, they have largely remained in a state of anomie (see below). This situation is reinforced by the actions of others whose professional and organisational practice only serve to encourage both accommodation and resistance on the part of the users. It could be argued that the latter appears to be an unconscious response to the social habitus that being a user of mental health services entails. Accommodation and resistance is used as a mechanism for exerting or enhancing their control in a cultural system largely created and maintained outside of their control.

The concept of anomie, as used here, refers to the problems of social integration in a system where the dominant values are conflicting or absent, or the individuals are not socialised to the cultural directives. It would appear that in the experience of many mental health service users with SEMI, apart from conforming to a 'sick role', they remain outside of the main culture of multiprofessionalism despite these teams continuing to exert considerable control over their social and cultural experience. Everett (1998) suggests allowing service users to have a voice can be a simple and cynical ploy by service planners to push through provision that meets only the needs of the planners, the service users being too disparate a group to provide for effectively, hence again the problem of representation not being representative.

Nietzsche (1977) suggests that the ideals of any society are merely the reflections of the ideas of its most powerful men. This notion is easily transferable to teams, where powerbroking is an everyday fact of life (Gellerman, 1974). Within the mental health team this may lead to a specific therapeutic focus which may marginalise the user, a type of therapeutic tail wagging the service dog. While the team may be indirectly influenced by outside 'policy' (for example, the concentration upon SEMI), the therapeutic response is invariably generated within the team. Once therapists adopt the mantle of a specific therapeutic approach, they then carry a great deal of baggage to any encounter with users, since it encourages a response to illness rather than health (Ashton, 2000) and leads to what Lippman (1922) refers to as defining and then seeing

(that which you desire). Responding to symptoms is rather mechanistic and leads to the client's voice going unheard or, rather, not understood. Different therapeutic approaches may translate the user's story in very different ways depending upon the professional's language and interests. Certainly diagnosis leads to therapeutic stereotyping as illustrated by Rosenhan and Seligman (1989). However it is considered, there is a difference between the concept of effective teams as an abstraction and the team as a functioning entity and whether it is effective or not.

In scrutinising what is felt to be effective in psychiatric care, Rogers and Pilgrim (1993) found that the most liked intervention was one-to-one contact with a mental health worker (it didn't appear to matter who). Further, one of the least desired interventions was group therapy, since this was viewed as being too 'medical'. Teamwork, as a concept, did not appear to be addressed among staff undertaking inpatient care. Further, Rogers et al. (1993) investigated users' views of the mental health professionals, finding that any scrutiny of teamworking was lacking, each profession being compartmentalised. Is this the perception held by service users? Vincente et al. (1993) and MacDonald et al. (1990) would cautiously agree. Both studies point to the psychiatrist as being the most identifiable member of the team and, further, that other team members interacted with the user for specific purposes, such as 'support'.

In examining the work of theorists, in the context of organisational culture, there appears to be an almost unquestioned assumption that the organisational structure is itself neutral, what Hearn et al. have described as a *'taken-for-granted non-problematic feature of social organisation'* (1989: 14-15). Both 'organisation' and 'the organisation' are the result of knowledge, practices and processes built up over time, which are reflected in a powerful discourse based upon ideas of rationality, efficiency, productivity and control. In the context of UK health services, in general, and mental health services, in particular, this discourse has been legitimised both by professional discourses and by recent policy initiatives aimed at providing safe, secure and supportive mental health services (DoH, 1998).

2.9.3 Service user movements

User movements have a long history. For example, the Alleged Lunatics Friend Society was very influential in the mid-19th century, and this group was a clear forerunner of current self-advocacy programmes (Campbell, 1996). However, the current focus on user involvement is wider and all embracing. Rogers and Pilgrim (1991; 1996) describe mental health user groups (MHUGs), in the UK, as a 'new' social movement on the basis that they are postmodern and have demands beyond static political agendas. Cohen (1998) takes this on board and sees the MHUGs as a possible instrument of change, helping psychiatrists to rethink concepts and practice.

One conceptual framework for actively participating in and contributing to the achievement of good mental health has been constructed around notions of consumerism, although this again has been criticised by Stacey (1988). Through the articulation of consumer behaviours, empowerment is gained. The concept of the consumer, borrowed from the private sector (Handy, 1993), gained more significance following the 1990 reforms and the NHS and Community Care Act (DoH, 1990). Within the context of mental health services, a series of patient's rights was published in 1997 (NHSE, 1997) which set out standards and rights specifically for those individuals coming into contact with mental health professionals.

Current policies, such as the *New NHS: Modern, dependable* (DoH, 1997a); *Saving Lives: Our Healthier Nation,* (DoH, 1999c) and the *NSF: Mental Health Services* (DoH, 1999a), recognise the role of the health care consumer. However, these (ideological) objectives can sometimes be difficult to translate into practice, resulting in major difficulties in moving from the rhetoric to the reality of user involvement. These can involve technical and logistical problems of user involvement, as well as professional and cultural factors arising from an unequal professional/patient relationship.

2.10 Education

Working Together (NHSE, 1998) and *Making a Difference* (NHSE, 1999) address issues of human resource management in the NHS. The recruitment and retention of nurses has become ever more difficult (Brindle, 1998), with a projected figure of up to 40,000 new students needing to be recruited by 2001 if the present trend of low entry numbers to the profession continues. These documents also set the framework for the future national strategy for the acquisition and enhancement of skills across nursing and other health care professional groups. In mental health nursing, this has sometimes been difficult to achieve (Rafferty, 1998). There have been some recent initiatives aimed at addressing this, for example the *Pulling Together* competencies project (Duggan, 1997) that looked at the future roles and training of mental health staff. Indeed, changes in pre-registration, which began with pilot sites in September 2000, are building upon the experiences of the past, particularly in the achievement of competencies allowing student nurses to be *'fit for purpose'* on completion of their training (Peach, 1999).

Educational consortia, largely responsible for the purchase of MHN education, also have a responsibility to ensure that the future workforce needs of service providers is known and that their workforce plans incorporate service changes and developments (DoH, 1999a). Further, educationalists and service providers are told to work in partnership, collaborate, and develop alliances *'to meet the challenges of providing quality education for quality care'* (ENB, 1996: 5). This is not an easy task. Many service providers have organised their resources around multiprofessional teams. However, as we have highlighted, the composition, purpose, management, resources, location and effectiveness of these teams can be extremely variable (Tudor, 1996; Corrigan and Garman, 1999). This situation becomes more complicated as these multiprofessional teams become part of a wider network of other agencies.

2.10.1 Service user involvement in education

Simpson (1999) examined the benefits of involving service users in the training of MHNs at post-registration level as part of the way in which community mental health teams (CMHTs) develop. The greater involvement of service users could be a powerful factor determining how mental health services might become more conceptually integrated, consistently provided to a set of national standards and economically and professionally effective. This conceptual integration has recently been described in accounts of clinical governance (Ledwith, 1999).

2.10.2 Multiprofessional programmes

The King's Fund London Commission (1997) suggests multidisciplinary training and education as a possible long-term solution to the problems of ineffective team and agency working (Norman et al. 1998). Indeed, Gournay (1997) suggests core multidisciplinary mental health courses with specific pathways for each of the specialist mental health professionals. This suggestion pulls the MHN into more specialist territory compared with other nurses. It is a move many MHNs may welcome since they fear their 'unique' contribution (in its multiple, but often blurred guises) can become diluted in multidisciplinary teamworking. Further, following the trend of some successful dual qualifications in social work and learning disabilities, a joint training of social workers (SWs) and MHNs is being considered in several educational institutions.

A difficulty with multiprofessional education and training is that it is assumed that such a programme would produce effective teamworking. As we have seen, there is a distinct lack of evidence that this is the case. Also, a problem exists in the establishment of a set of core competencies and outcomes for such programmes. By whose standards is effectiveness being measured? Which disciplines and professions need to work and learn together, under what particular circumstances, and to what common ends? The Sainsbury Centre, in the report

Pulling Together (1997), identified 27 competencies for specialist staff which provoke Norman et al. (1998) to claim this to be a simplistic way of addressing and constructing professional identities. They believe interprofessional working cannot be improved through a 'top-down' approach alone: *'It is necessary to establish both uni- and multiprofessional developmental training programmes at local level to allow professions to see themselves as others see them and so challenge and modify their own professional identities'* (1998: 23).

2.10.3 Professionalism and multiprofessionalism

Here we deconstruct, in detail, a range of texts relating to professionalism and multiprofessionalism.

Norman et al. (1998) illustrate well the dilemmas of the multidisciplinary or interdisciplinary potential of teams, especially CMHTs. On one hand they are clear about the problems: there have been *'systemic problems with inter-agency and multiprofessional working as threatening to fragment the mental health services'* (1998: 5). They conclude some of the potential team members are reluctant or poorly placed to co-operate, such as *'overworked consultant psychiatrists with low morale who are unable to generate the necessary motivation for inter-professional working'* (1998: 16). Nevertheless, they conclude that interprofessional working is not an impossible dream. It is not *'fundamentally flawed'* (1998: 24) and it can still be a way forward to the vision of *'an integrated, seamless service'* (1998: 21). Also on the positive side, Miller et al. (1999) see clear benefits of effective collaboration in terms of *'patients, carers and the team itself'* (1999: 219). They prescribe the sort of training that Norman et al. (1998) seemed to recommend – stressing *'multiprofessional groupwork through scenario-based learning'* (1998: 221). Hibberd (1998) offers support for this kind of approach. The call is again for *'seamless care'* (1998: 274). The way forward is for each member to have *'a clearly identified role and equally valued responsibilities'* within *'a new philosophy of co-operation, negotiation and shared responsibility'* (1998: 281). Chalk (1999) is also optimistic, calling for more clarity and better planning in relation to teamwork learning, but also noting that there has been *'a barrage of criticism'* (1999: 13). Others have sought in more procedural detail to try to outline and evaluate multiprofessional multi-agency practices, such as Hunt's exploration of the value of *'shared records'* (Hunt 1999).

There are a number of counter-balancing factors that appear in the literature that we also need to take into account. Although researchers like Hibberd (1998) are broadly in favour of the developments, he stresses that multidisciplinary teamwork requires an *'organic'* (1998: 280) organisational system, i.e. one that is fluid, flexible and adaptable, as well as a shared vision and a set of core skills (see also Hannigan, 1998). He also warns against the confusions and conflicts consequent on the development of generic roles. He is a 'splitter' rather than a 'lumper' when it comes to defining boundaries and roles. But it is not clear how fluidity in context can be kept separated from clarity in roles. More sceptically, Berragan examines the nature of professional knowledge, drawing widely on authors as far apart as Habermas and Polanyi (Berragan, 1998). Stressing the tacit nature of knowledge and its inherently interesting nature, Berragan concludes that professional knowledge includes a lot more than can be reduced to evidence-based procedures: there is the intuitive, the aesthetic and the ethical. We may conclude, therefore, that teamworking must offer exchanges between professionals that are not just about knowledge or competence but also about values – a theme that emerged in our vignettes. (See Chapter 10, for example, for the differences between SWs and community MHNs (CMHNs) in terms of cultural contrast and sense of humour.)

Gill and Ling (n.d.) express doubts about the effectiveness of interprofessional shared learning as a means to developing teamwork skills, saying it *'promises more than it delivers'* (p. 92). They offer a definition of multidisciplinarity based on problems or needs addressed *'by purely disciplinary solutions'* (p. 74). Barr et al. (1999) agree that 'multi' means 'learning alongside' while 'inter' implies learning from each other (the Centre for Advancement of Inter-Professional

Education (CAIPE) distinction), but they also note that evaluation of successful examples of interprofessional learning are *'elusive'* (1999: 533). In particular they explore the difficulties of being able to determine the outcomes of teamworking in terms of improved client care, given the number of mediations between team practice and patient recovery or deterioration. Nevertheless, they consider the ideal of a Cochrane style meta-analysis in directing future practice in this area. Meanwhile, we might infer that multiprofessional teamworking remains unproven.

Hannigan (1998) also notes that there are tensions between the apparent need to remove boundaries that are *'increasingly difficult to justify'* (1998: 4) within a context where the market-driven logics produce counter-productive *'unintended and perverse incentives'* (1998: 4). This theme of 'competing tensions' is further developed by Wells (1997: 339). Wells indicates a number of these tensions between high profile accountability and the assertion of professional autonomy, as well as the need to offer professional services in a context where there is little control over resources. Wells' concern is that managers are tempted to identify outcomes which are explicit and achievable in a way which may distance management and policy makers from the reality of the *'felt'* experience of policy (1997: 340). In particular, he seems to be indicating (in different language) the tension between the 'economy of performance' and the subjective experiences of practitioners in relation to what we refer to elsewhere in this report as the 'ecology of practice'. These sorts of tensions are also remarked upon by Onyett, who is concerned most with the pressures between *'autonomous professional practice'* and *'operational management fiat'* (Onyett, 1997: 4 1).

A more sophisticated account of professional dilemmas in relation to collaboration and professional identity is offered by Barker et al. (1999). They argue that the identity of the professional MHN is caught between three 'dispositions', the Ordinary Me, the Pseudo-ordinary Me or Engineered Me, and the Professional Me. Stressing that these are not separate identities and lack *'firm boundaries'* (1999: 275) they argue that nurses have to *'toggle'* between these three domains in order to undertake their work as professionals. This notion of identity and its consequent capacity for collaboration has something in common with the ways that we found professionals 'juggle' between different registers of value and meaning – in relation to the 'economy of performance' and the 'ecology of practice'. It may suggest that it would be worth pursuing in greater detail the nature of the splits, overlaps and leakages which invest current professional identities and which therefore invest the possibilities or problems of collaborative work between different professional groups.

2.11 Summary

As can be seen from the scale of this literature review, we believe that a deep understanding of the contextual issues is vital in order to undertake this study. The turbulent context in which mental health is situated needs to be recognised and explored so that an agenda for education and training for multiprofessional teamworking can be addressed effectively. A number of concepts, contradictions and tensions have been noted which influenced the direction of our research. Below we summarise the significant issues.

The need to achieve greater collaboration, partnerships and participation between health care professionals and health and social care professionals and, more recently, between these individuals and service users, cannot easily be achieved through policy coercion or administrative fiat (Norman et al., 1998; Warne, 1999). Nor does it imply bringing together individuals in a particular setting with a particular focus for practice, as in the case of multiprofessional teams. Indeed, the historical development of more integrated mental health services is not littered with good examples of best practice. Further, there is little empirical evidence to support the presumed relationship between integration and achieving effectiveness across a network of service provision. It seems from our review of the literature and our data that to develop a more critical notion of professionalism and of multiprofessional collaboration, such theories have to address dominant cultural, economic and professional factors. This report,

therefore, establishes carefully contextualised accounts of the management of change, induction into new roles (Norman et al., 1996; Biott et al., 1997), the effects on service users and the implications of these for the education and training of MHNs, in what we consider to be a turbulent environment. In this respect Pirrie's (1999) work is – at least metaphorically – fundamental. She argues that the very language with which we begin to address problems of collaboration and multidisciplinary work is deceptive. It is a language of maps, territories and disputes. She emphasises instead the *'peculiar dynamics'* of collaboration and prefers to dismiss the drive towards seamless *'integration'* (1999: 120) as somewhat illusory. Perhaps the best we can hope for, she concludes, is an *'episodic coupling'* (1999: 121). Our conclusions would not be so distant from that more subdued aspiration.

On deconstructing the variety of teamwork practices within diverse care settings, there are a number of strategies developed from the work of Lather (1991) and Mohr (1995) that we believe could be taken up by future researchers and clinicians concerned with the dynamics of professional practice within the multiprofessional team. Delivery of appropriate nursing care that encompasses and runs the gamut of human experience of emotional/psychological distress is inextricably bound up with the teamwork dynamics and disciplinary practices that make for contemporary mental health care. How nurses attempt to make sense of the complexities and confusions inherent in human subjectivities and relatedness, the possibilities of differences in readings and interpretations of human experience must be acknowledged, especially within the contexts of teamwork.

A view which is wary and, indeed, critical of seeing teamwork in a *'thinglikeness'* way is outlined by Fairhurst (1998): *'Just as concepts of pain and suffering have no intrinsic meaning, it is only with the furnishing of a context that pain and suffering make sense'* (1998: 128). Similarly, we are suggesting that emotional distress/mental health difficulties/mental illness and the ways in which teams work to ameliorate this distress cannot be considered outside of the contexts within which they happen: *'to introduce them "out of the blue" and make them the focus of discussion is to invite puzzlement'* (Fairhurst, 1998: 128).

We hope, therefore, that this report will enable the multifaceted meanings of teamwork for mental health care practice to be situated within the real living contexts of people's experience.

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A mixed methodological approach was used incorporating data collection via five Aspects:

- Aspect 1: Literature review and documentary analysis
- Aspect 2: Orientating focus groups
- Aspect 3: Initial survey
- Aspect 4: Case studies
- Aspect 5: Report-and-respond survey

We collected data using an inductive approach based on a form of grounded theory (Aspects 2 and 4). This involved tracing a variety of job performances of the MHN in different work and team contexts and then seeking the implicit, or explicit, models of professional practice, as well as the knowledge-use strategies employed by the professional in taking practical decisions. We also used a deductive approach based on describing and then understanding the processes through which prescription becomes, or fails to become, action (Aspects 1, 3 and 5).

This dual process identified the effectiveness of the MHN's role, including the role as a member of a multiprofessional team, as perceived by a triangulation of service users' needs, managers' perceptions and fellow professionals' perceptions. It also highlights the match or mismatch between such performance and current education and training. Appraising role effectiveness against educational congruence enabled overall judgements of educational worth and the identification of the implications for educational provision and evidence-based professional knowledge to be developed.

Each Aspect built upon the preceding Aspect/s. Both statistical data and rich descriptive data were collected and analysed.

3.1 Aspect 1: Literature review and documentary analysis

3.1.1 Review of the literature

The review of the literature was a continuous process throughout the study. It contextualised empirical data and contributed to the development and generalisation of theory. Strands of the literature search include:

- contexts of mental health care
- mental health policy and research
- theory concerning the nature and components of professional practice
- dimensions of multiprofessional multi-agency teams, such as structural, cultural and professional issues
- user involvement.

We also examined literature concerned with professional effectiveness and educational congruence and the differing perspectives of stakeholders in relation to these and other issues such as change, teamworking and evidence-based practice.

Our extensive reading of the literature throughout the evaluation stimulated us to revisit our data on several occasions for verification or clarification. For example, the literature discussed the socialisation of professionals into their roles. This led us to look for evidence of socialisation patterns when we were in the field. Conversely, after analysing some of our data or

developing theory, we would then return to the literature for further insights in relation to what was emerging.

3.1.2 Documentary analysis

The documentary analysis was also an ongoing process. This Aspect specifically addresses the first aim of the project. We analysed curricula and health policy documents.

Curriculum documentary analysis

In this analysis we traced the ways in which national policy (statutory, regulatory, etc.) is translated into programme philosophy at institutional level, via nursing models and curriculum models, and, eventually, into specific module provision (in terms of CFP and branch studies). In addition, we established *in theory* how different levels of practice are characterised in curriculum outcomes. In this way, we sought to deduce the models implicit in various conceptualisations of 'mental health nursing' or more broadly of 'professionalism'.

Educational institutions throughout England, incorporating all eight NHS regions, were approached for their curricular documents. We analysed the documentation in relation to:

- pre-registration DipHE awards (CFP and mental health branch programme)
- degree programmes
- a range of post-registration programmes (e.g. Community Psychiatric Nursing, Counselling, Psychotherapy, Cognitive Behaviour Therapy and Rehabilitation – these being the most likely to reflect nursing contributions in a variety of multiprofessional multi-agency settings).

Analysis of health policy documents

This analysis examined mental health policy documents, educational policy documents, research documents and current policy documentation, specifically relating to educational issues, including the spate of 'New NHS' proposals from 1997. We also examined the promotion of a competencies approach by the Sainsbury Centre and others as well as mental health literature such as: *Fitness for Practice* (UKCC, 1999), *Making a Difference* (NHSE, 1999) and *Working in Partnership* (ENB, 1997). This enabled us to understand the issues surrounding multiprofessional teamworking in mental health in a carefully contextualised way.

Further, the documentary analysis highlighted significant issues to include on the initial survey (Aspect 3), not only in relation to educational issues but also professional and practice issues. In Aspect 4 (the case studies) briefing notes made from the curricular documents for the specific case study sites helped the team members to understand the different pedagogical emphases in their educational context/s, for their own site and for other case study sites.

3.2 Aspect 2: Orientating focus groups

The data collected from the focus groups and the initial survey centre around Aims 2, 3, and 4.

The intention of the focus group strategy was to help us develop an initial orientation to key concepts and issues that we needed to consider while undertaking the study.

For each group (apart from the service users and survivors group) we 'brainstormed' the roles, or job titles, of individuals who could be a potential member of the focus group. Using information and contacts gained from the field visits, and other contacts team members had previously established, names of individuals were matched against the role/job titles. These individuals were then invited to attend the relevant focus group session. The service users and survivors were recruited through a survivor of mental health distress.

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Recruiting members to the focus groups took several weeks of sustained effort. General practitioners (GPs) and psychiatrists declined to be involved in the research at this stage. Reasons given included demands from their other work commitments, the time of the sessions, the lack of remuneration for the task. Nationally and locally GPs were involved in responding to the primary health care changes. Other professionals, such as OTs, offered to complete a survey rather than attend the focus group. Approximately 65% of those who agreed to participate in the focus groups attended.

The focus groups comprised:

- individuals involved in education – mental health lecturers, pre- and post-registration mental health students
- service professionals (i) – with a mental health background
- service professionals (ii) – with a mental health background, but in a different geographical practice setting to group (i)
- service professionals (iii) – MDT members
- service users and survivors
- voluntary agencies and other groups representing the service user's perspective.

The initial analysis of the focus groups provided the team with several key issues to be included in the three surveys developed during Aspect 3. The analysis of the focus group data also provided data to be contrasted with the analysis of the initial survey data.

3.3 Aspect 3: Initial survey

We developed three separate surveys for the following individuals:

- those involved in education (lecturers and students)
- service professionals (purchasers and commissioners, managers, MHNs and multiprofessional team members)
- service users and carers.

We used a mixture of 'specific' questions (directed at the respondents the survey was intended for, as for example those involved in education) and 'generic' questions (asked in all three surveys to enable direct comparisons to be made). The study was piloted.

3.3.1 Administering the surveys

We stated in the proposal that 800 surveys would be administered by mail to eight sites throughout the UK. However, as a result of the resistance we experienced, in both Aspects 1 and 2, from individuals to participate in 'yet another piece of research' we decided to personally administer the surveys in the eight regions, in the hope of a higher response rate. Also, since the sites were to be used for the case studies, we felt time spent visiting individuals and building up a positive relationship would be beneficial. The surveys were administered over a four-month period (November 1998-February 1999).

3.3.2 Selection of the eight regional sites

We developed selection criteria for the eight regional sites and then more specific criteria for organisations and individuals within each region. The eight NHS regions were our starting point for the selection of our sites. The educational institutions in the regions were established first, since we wanted to trace the aims and objectives inherent in the curricular documents through to practice and also link practice to curricular philosophy and outcomes. We sought the advice of Board officers in the regions, as well as our Steering Group, as to interesting cases. In addition, we evaluated the programmes offered by the educational institutions

within each region, their size, age, whether they were 'old' or 'new' universities, geographical location and population demographics. The final eight educational institutions in our sample represent six of the NHS regions in England. All institutions provide both pre- and post-registration programmes in mental health. Six institutions are 'new' universities and two are 'old' universities.

Lecturers at the educational institutions were instrumental in providing us with the key individuals in the mental health service areas, as well as service user/survivor groups, from which we were able to draw our sample. The practice care settings used in the sample, therefore, were linked with the educational institution that provided the educational needs of the service professionals in that area. We aimed to have a comprehensive mental health service represented (primary, secondary and tertiary). However, at the survey stage, we experienced resistance from GP practices to complete the surveys. This highlighted to the team the importance of their voice being represented via the case studies (Aspect 4). The sample of care settings represented at this stage included the following:

- CMHCs (including multiprofessional centres)
- day care centres – both funded by the health service and social services
- acute inpatient units
- regional secure units – e.g. forensic, challenging behaviour
- specialist services – e.g. drugs and alcohol, mental health and deafness.

Service user and survivor groups were suggested to us by individuals working in both the educational institution and the service areas. We also included voluntary groups, self-help groups and special interest groups such as MIND.

Around a hundred surveys were administered in each of the eight sites. This number varied slightly from region to region, particularly with the service users and carers who were, on occasion, less willing to participate.

The results from the survey analysis were used during Aspect 4 of the evaluation (the case studies). We used the information to decide whom it would be beneficial to interview, what Aspects needed to be observed and which documents would be helpful to collect while in the field. The survey also provides the Board with a national overview in relation to the issues raised under the project aims.

3.4 Aspect 4: Case studies

Case studies combined on-site documentary analysis (operational policies, clinical protocols, service specifications and audit outcomes) with individual interviews of key players, group interviews, observations and critical incident analysis (the latter has been used previously in psychiatric nursing studies: Jacobs, 1973; Cormack, 1983).

We invited individuals from the three categories of survey respondents (education, service professionals and service users) to report on practical and theoretical aspects related to mental health nursing care in different care settings. The group interviews incorporated features of focus group interviewing, as the latter parts of the interview encouraged participants to envisage ways forward for the role, organisation and relevant policy and practice contexts. The group interviewer role combined aspects of ethnographic interviewing and facilitation (Wilson, 1997). The critical incident deconstruction encouraged participants to be reflective about practical incidents, in order to deepen their understanding and raise their consciousness in relation to significant issues. Several observational sessions, in different care settings and educational environments, provided us with rich descriptive data of the general milieu in which multiprofessional teamworking was positioned.

- The eight sites which were identified in Aspect 3 (the survey), including the educational institution, practice settings, service user groups and voluntary agencies, provided the locations for the fieldwork.
- The case studies were undertaken over a period of nine months.
- Visits to each site ranged from a day to a week at any one time, and sites were revisited until an average of 12 days had been completed (the range was 10-15 days). A total of 101 days was spent at the case study sites.

Data from this Aspect of the evaluation were descriptive in the form of taped interviews and extensive fieldnotes. The tapes were transcribed. Thematic analysis was used to enable significant issues to emerge from the data. Where possible, second interviews with respondents were undertaken in order to share our interpretations in an attempt to gain some intersubjective agreement in relation to the analysis. Also, a second interview enabled us to probe certain issues further in order to increase the 'richness' of the text.

All team members were involved in the case studies. We visited educationalists, service professionals and service users so that our data could be triangulated. However, as the survey had shown us that there was no significant regional difference in the respondents' responses, we decided each team member would focus on particular features that we felt were interesting and accessible in each site. For example, one of us had excellent access to some interesting service user groups, while another looked at post-registration provision, another looked at pre-registration and others selected different care settings for investigation. This approach provided us with depth to the evaluation as well as breadth.

3.4.1 The case study sites and participants

The eight case study sites were widely spread throughout England. Coastal regions, rural and urban communities are included. Cities experiencing high unemployment, poverty and rejuvenation are represented, as well as wealthy, well-resourced areas.

All the universities used have either expanding schools of nursing and midwifery, or schools of health. A host of courses, from National Vocational Qualification (NVQ) Levels 2 and 3 to post-graduate and professional courses, in a range of areas including mental health, are typically offered. All the schools/departments have effective links with NHS trusts and private sector providers.

The mental health service provision across the regions does not vary significantly, however, there are variations within regions. Some areas with high unemployment are in extreme need of better resources. A plethora of services is still provided in old-fashioned asylum-type buildings. Interprofessional working is hindered in many areas because of lack of funding. Some buildings are barely able to offer private rooms for consultations with clients at CMHCs. Other areas are better resourced. For example, in one region there is a purpose-built mental health centre which houses an interdisciplinary CMHT on one floor and an acute inpatient centre on the second floor.

There are well-developed examples of user/carer organisations, actively involving themselves in the development of community and hospital services, in some regions, but this is not commonplace. In other regions a large amount of care is provided by voluntary and charitable organisations.

An example of a case study site and the participants is given in Table 3.1, below.

We conducted interviews and/or observations with the participants. Some of the participants were visited more than once.

Location	Participants
School of Health, University	Acting Head of Department Principal Lecturer Senior Lecturer, Mental Health – Examinations and Assessments (Pre-reg.) Senior Lecturer – Forensic (Post-reg.) Three further Mental Health Senior Lecturers (Pre- and Post-reg.) (separate interviews) Six Mental Health lecturers (group interview) Pre-registration Mental Health students (n=30) new into branch studies Pre-registration Mental Health students (n=2) six months into branch studies and mainly 'mature' Post-registration students (n=7) taking forensic module; multiprofessional group Post-registration Mental Health students (n=5) 'topping up' their qualifications to B.Sc.
CMHT in a poor area with high unemployment	Counsellor Consultant psychiatrist Three CPNs specialising in drugs and alcohol CMHT – team manager (CPN); two further CPNs and two support workers (group interview) Users
University based, but work with the CMHT for 20% of their time	Two link lecturers
CMHT in a relatively poor area, lower unemployment than the previous CMHT, semi-rural location	Three CPNs Support worker Manager, CMHT (CPN)
University based, but work with the CMHT for 20% of their time	Link lecturer
Drop-in centre run by the Social Services	SW/Manager Support worker Art therapist Users
GP practice, high unemployment area	GP
Offices within large hospital, individual purchases the mental health services and education for a very large geographical area, taking in the city and other regions	Sector Manager of Mental Health Services
Purpose-built MHC. Same as above, but this manager has a much smaller area and is in a more rural area, more richly resourced	Sector Manager of Mental Health Services
Acute inpatient; 20 beds, 160% bed occupancy, very tight resources	Two ward managers (separate interviews) Staff nurse – qualified for six months Approved SW Support worker Users
A voluntary organisation, which is a charity, and was originally set up by users. The organisation expanded and now incorporates supported housing, a base centre, a telephone help line, etc.	Two managers of a voluntary Mental Health Group (separate interviews)
Mental Health Centre housing a multiprofessional CMHT; a day centre, plus an eight-bedded acute inpatient centre	Manager, Mental Health Centre Ward clerk Occupational therapist Two mental health staff nurses Manager, acute inpatient centre General nursing student (first year) CPN Support worker Outreach worker
Day centre, managed by a CPN	Manager

Table 3.1: Example of a case study site and participants

3.5 Aspect 5: Report-and-respond survey

The problems of combining case study and survey are well-known. Survey offers the reliability on which policy-makers base decision making, yet the insights of case study are central to understanding the processes through which innovations succeed or fail (Simons, 1987). Recent experience in programme evaluation (Stark and Elzubeir, 1994; Stronach et al., 1994; Stronach et al., 1996) suggested to us that a hybrid instrument giving interim feedback to a survey audience based on early research (reporting) and designed to provoke further comment (responding) can result in richer data and tighter evaluation. It is a form of reporting that seems to prompt dialogue and results in improved response rates (Stronach et al., 1996). Thus, we produced a report-and-respond (R&R) survey on the basis of the initial survey and case studies. This encapsulated findings we had gathered at that point, as well as raising further issues for comment. Taking the findings back to participants in this way offered the opportunity for them to verify or refute the responses we collected, as well as gain insights into the themes which emerged during the study.

The R&R survey was piloted and administered (n=400), where possible, to the individuals involved in the initial survey. All categories of participants from the initial survey were used, i.e. service professionals, educationalists and service users and carers. However, unlike the initial survey they did not receive a separate survey – the R&R survey was the same for all participants.

3.6 Final reporting

The data from these five Aspects were used to address the aims of the study. We had developed the original project brief by adding Aim 4 and extending Aim 5. We used this fifth aim to provide a focus for our team discussions and critical analysis at a later stage in the evaluation. The reporting associated with this aim can be found in Chapter 11.

3.7 Confidentiality and anonymity

This report does not identify by name any region, educational institution, service area, voluntary agency or service user group participating in this study. In addition, no individual is named. All names given are pseudonyms.

3.8 Ethical issues

We used the ethical guidelines established by the RCN when conducting our research. Respondents involved in each Aspect of the research were fully briefed about the nature and purpose of the research. Abstracts outlining the research were offered to all individuals we liaised with. We sought consent from relevant gatekeepers and/or the participants themselves, as well as informing all participants when interview sessions were to be taped. The survey was accompanied by a covering letter providing information to the potential participants. We clarified our ethical position with heads of institutions before approaching individuals 'at the grass roots'. Some organisations took the written information we supplied them with to an internal ethics committee. We accepted any requests from groups and individuals not wishing to participant in the study or to continue with their participation.

3.9 Limitations of the study

A number of limitations were identified relating to the methodology employed in this study. These are noted in the report and are summarised here.

Of the 31 educational institutions approached for curriculum documents, only 16 responded positively. (See Chapter 4 for the reasons why institutions appeared reluctant to provide us with their documents.) The institutions that did respond shared a wide range of documentation including a variety of pre- and post-registration curriculum documents,

placement details and assessment criteria. Although the response rate limited our sample of institutions we were able to undertake a thorough analysis of the documents we received, which may not have been possible if larger quantities of documents were involved.

Of individuals who said they were attending the focus groups, only 65% actually did so. This resulted in some groups not being represented at this stage. This did not unduly concern us at the time since we had several opportunities to collect their input during subsequent Aspects of the study. The data collected provided us with a good orientation to the issues pertinent to the evaluation.

Given the difficulties we experienced in acquiring curriculum documents, the team decided to deliver the surveys in person to the eight regional sites, as opposed to mailing them. Conversations with educational institutions and service professionals highlighted that, at the time, many requests were being made by researchers for documents and for survey completion. This 'saturated' climate may have affected our response rate (48% for education, 43% for service professionals and 21% for service users).

It became apparent that some service users had difficulty completing the survey. The research team did take this into consideration and read the questions to the respondents where necessary. However, perhaps due to their illness, many service users did not want to be involved in the survey completion. A further group of respondents under-represented in the surveys was GPs. Our attempts to reach this group via letters, visits, telephone calls, as well as personal contacts only elicited a handful of responses. Pressure of time, lack of interest and lack of financial remuneration for their involvement were cited as reasons for their absence. We noted the small responses by both the service users and the GPs at the initial survey phase and endeavoured to ensure we captured their voices in the case studies (see below).

During the case study phase we were fortunate to have excellent access to user organisations and individual service users in one particular region. Since our survey results had shown little regional variation we were satisfied that collecting data on users' experiences predominantly from one region would not necessarily bias the results. (We did, of course, collect users' experiences in other regions.) Six regions were successful in obtaining a medical viewpoint, for example, GPs, consultants, trainee doctors. Ideally we would have welcomed greater medical representation, but this proved difficult. We are satisfied, however, that our participants did enable us to provide a medical perspective. In addition, we were able to recruit other members of primary health and community care services in all eight regions.

The R&R survey had a 33% response rate. Given the slightly negative attitude towards survey completion, which we had noticed early in the study, we had anticipated our response rate. This survey was used to feedback an overview of the study findings to date to participants and to invite a response. The responses from the returns did not highlight any major issue with the findings we presented.

An unavoidable situation involving a delay in the publication of the NSF for mental health caused some participants to be reluctant to offer an opinion of the possible future of mental health nursing and mulitprofessional teamworking. In addition, an uncertainty about the future involvement of PCGs with specialist mental health services also inhibited discussion of possible future service structures and relationships. Sometimes a 'wait and see' philosophy predominated.

We believe the methodology provided empirical depth and breadth to the findings of the study. We are satisfied that any limitations did not preclude us from achieving the aims of the study and in making a contribution to evidence-based professional knowledge in the field of mental health education.

3.10 Summary

The orientating focus groups, initial survey, case studies and the returns from the R&R survey give the findings both empirical depth and breadth. The exploration of case study themes and issues in the R&R survey help test the generalisability of case findings, maximising opportunities for 'progressive focusing' and make theorising a continuous feature of the inquiry. Our analysis of the data combines elements of grounded theory (Glaser and Strauss, 1967) emanating from the survey and the case studies, as well as drawing on relevant theories of professionalism, multiprofessionalism, needs analysis and evidence-based practice. In addition, we feel that some of the central concerns of our work, like 'effectiveness' and 'congruency' imply a comparative dimension to the study, especially in relation to issues concerning multiprofessional multi-agency settings. This need to understand the innovation in context was reflected in the 'ecological' approach that we took. We believe that such a synthetic and multiperspective approach to data analysis contributes to the more general Board research goal of developing systematic evidence-based professional training for nursing (Miller et al., 1994; Phillips et al., 1994; Eraut et al., 1995) and in related professional contexts in health, medicine and education.

Our approach to the research does not offer definitive judgements on the relationship between the discrete role of the MHN within the multiprofessional multi-agency team in a range of care settings, and the educational provision for these roles. However, it provides formative and timely feedback to the Board, as well as informing a contextualised summative judgement on the current situation, and in doing so, contributes to the development of evidence-based professional knowledge.

The documentary analysis traced the ways in which institutions translated policy into curriculum specification and implementation. We developed a series of profiles which were subsequently contrasted for any apparent shifts, matches or mismatches:

- policy profiles to indicate the intentions of relevant stakeholders
- implementation profiles to indicate how philosophies have been translated into educational principle and procedure
- practice profiles to indicate how the previous two profiles translated into practical application.

We assumed that the evaluation of multiprofessional multi-agency teamwork could only be addressed in a comprehensive way, i.e. that learning to work in such a way was likely to be influenced by the overall approach of the programme, either in terms of nursing or pedagogical models, CFP or branch structure, or 'shared learning' assumptions. We sought to uncover, for example, what nursing models and pedagogical models appeared implicitly and/or explicitly to influence professional decision making and action and what the origins and influences were. Here we outline the educational policy and the implementation profiles. The practice profiles were developed at a later stage in the study, when we undertook our fieldwork analysis.

4.1 Educational policy

4.1.1 Philosophy and policy into programmes and curricula

We examined the policy background through which models of and for care are expressed as ideals and translated into specific educational policies. We believe that issues of 'teamwork' and 'multiprofessionalism' cannot be separated from questions of role, identity and context. We noted the turbulence, or messiness, involved in significant changes in policy, knowledge base and resources. We noted also the possible naiveté in treating different levels of the policy-to-practice continuum as simply acting on each other; policy-making, to an extent, can be the outcome of implementation. It could be argued that unintended change is always the ghost at the innovation feast. Indeed, organisational theorists, like Mintzberg (1998), would argue that we should pay more attention to the ghosts than the guests, for the former may be more interesting than the latter.

Most insistently, the policy documents demand a modernisation within the *New NHS: Modern, dependable* (DoH, 1997a). The purpose of the first section of this chapter is to look at the policy rationales and educational strategies that have resulted from recent modernising developments, paying particular attention to *Fitness for Practice* (UKCC, 1999) and the associated policies of the NSF (DoH, 1999a), as well as proposals for clinical governance and audit, evidence-based practice and lifelong learning. This enabled us to tease out some of the educational meanings of the current policy context and to show a range of possible inherent dilemmas.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) Commission for Education argues:

> *'While diversity of the system is a strength, and we would not wish to undermine it by making detailed, prescriptive recommendations, we do believe there is merit in adopting a common approach to defining outcomes from pre-registration educational programmes to ensure that all newly-qualified nurses and midwives are fit for practice.'* (1999: 1.3)

The emerging rationality, then, is to extend the homogeneity of the education policy system by requiring of it more specific outcomes and common standards. The pressure for this policy change can be seen in the 1997 Sainsbury Centre's promotion of the 27 core competencies (Sainsbury Centre for Mental Health, 1997) and the Board's riposte (ENB, 1999). The Board, however, did accept that core competencies were:

> *'... a part of a wider recognition among a range of professions of the need for greater specificity and national agreement regarding the skills, knowledge and attitudes necessary in those who care for the mentally ill.'* (ENB, 1999: 7.7)

In terms of current government policy, such homogenising extends a more universal notion of rationality to cover a wider range of circumstances, while still invoking the need for local needs and contexts to be taken into account. This may be a step towards a national curriculum, although a more guarded one than those taken in professions like teaching.

We analyse policy in line with the thinking in *Fitness for Practice* (UKCC, 1999), that is, in terms of *rationalities* and *contradictions*. The rational moves the documents envisage are:

- *'refocus[ing] pre-registration programmes to address practice issues'* and outcomes, acknowledging a current lack of *'practical skills literacy'* (1,16; 1,11; 4.2)
- insisting that *'all students ... demonstrate achievement of common outcomes'* (3.44, original emphasis)
- introducing *'student-centred and facilitative'* pedagogies (4.10)
- developing portfolios and *'self-assessment'* aimed at *'agreed learning outcomes'* within the framework of a *'formal learning contract'* (4.11; 4.28)
- creating a *'growing emphasis upon an improved capacity for teamwork'* (2.18)
- accepting the notion of a *'career of changing roles, lifelong learning and continuing professional development'* (1,4)
- reconciling a broad competency approach with one which is *'patient and client centred, based on holistic, partnership approaches to care'* (2.28)

It appears that the aim is to centre educational policy on a notion of competency:

> *'... a set of learning outcomes for pre-registration programmes to cover the knowledge, understanding, skills, abilities and values expected of newly-qualified nurses or midwives.'* (4.7)

Competency, therefore, becomes a narrative of health education rationality. Indeed, competency is not new to nurse education; Phillips et al. (1994) examine the assessment of competencies in nursing and midwifery education. Further, the standard of such competency should be *'the skills and ability to practise safely and effectively without the need for direct supervision'* (4.8), but should also include the ability to meet 'future health care needs' (4.14).

If competency prescriptions are invocations of the real, they must invoke an ideal against which to stand. In this case the real is variously portrayed as *'no longer routinised, task-oriented roles'*; instead they are *'patient and client centred'* (2.28). The education for such roles stands in contrast with *'conventional approaches to education [which] tend to be teacher-centred and didactic'* (4.10). Instead, competency approaches demand a *'student-centred and facilitative approach'* (4.10) and lead to *'a symbiotic relationship between understanding and doing'* (4.14). Such a symbiosis, the authors of *Fitness for Practice* conclude, closes the gap between theory and practice, as well as the ideal and the real, since in the past: *'students are taught in the classroom about ideal situations which they rarely, if ever, encounter in practice'* (5.14).

We believe this new rationality harbours a number of potential and/or actual contradictions, some of which the report (UKCC, 1999) at first acknowledges but then spirits

away. For example, the UKCC Commission for Education acknowledges 'paradoxes' between technical competence and holistic care. Success lies in *'managing the contradictions'* (UKCC, 1999: I,6). But, later in the report, these paradoxes become reduced to a matter of *'balance'* (3.62). We believe other 'paradoxes' are not acknowledged.

The reconciliation between a competency approach and a holistic approach is claimed but not demonstrated. Competency approaches are usually located as instrumental and practical in nature. They accord with a *'fit for purpose'* view of nursing (UKCC, 1999: 4.2). But notions like 'holism' and 'student-centredness' are retained as unproblematic aspects of a competency approach. The contrast between the professional philosophy expressed in the Board's 1997 pamphlet *Mental Health Nursing: Working in partnership* is instructive. It stresses the personality of the MHN, the relationship with patients and concludes *'honesty, and simply being human yourself, are important'* (ENB, 1997: 2 and 4). One could argue, however, that honesty is not a competence, nor personality a skill.

The competency approach is combined with notions of 'governance' and 'audit'. These are claimed to be aspects of self-regulation. Such claims may be difficult to reconcile, as the juxtaposition of these two bullet points in *Making a Difference* (NHSE, 1999: 56) inadvertently suggests:

- *'The Government supports professional self-regulation but is committed to making it more open, responsive and accountable.'*
- *'Subject to consultation and legislation, it will establish a new streamlined regulatory framework for nurses, midwives and health visitors.'*

The Department of Health reaffirms elsewhere in the document that it *'will in future take more direct responsibility for the shape and direction of nurse and midwife education'* (UKCC, 1999: 4.13). It could be argued there is something of a 'paradox' here between professional self-regulation and managerial control. The same paradox appears in the NHS definition: *'... professional self-regulation provides clinicians with the opportunity to help set standards. A modernised regulatory system will allow the professions to more openly account for how standards are set and enforced'* (NHSE, 1998: 9, our emphasis).

It is assumed that general prescription and local need can easily co-exist and that liaisons between individuals and professionals can be unproblematically described as *'partnerships'* (2.28) which are necessarily productive: *'interprofessional teamwork improves the quality of care provision'* (5.36). We argue, however, that the capacity for local specification of provision is by definition decreased by a national competency approach. The Board's rationale was that such guidelines were:

> *'... prepared by the Board to enable curriculum design and development to be as creative as possible within the standards set by the Council.'*
> (ENB, 1994: 6)

In turn, issues like 'ownership' become important.

As we saw, the new policy constructs itself as the 'real' versus the somewhat discredited 'ideal'. One of the authors of this report noted in an earlier study of competency in teacher education in Scotland that invocations of the 'real' as opposed to the alleged 'ideal' tended to be just as divorced from empirical research into the nature of the alleged 'real': *'it is once again the supreme irony of the 'competence movement' in general ... that it never quite manages to find out what the reality is on which it is so insistent'* (Stronach et al., 1994: 137). The policy also constructs itself as the 'new' versus the 'traditional' in potentially problematic ways. As the next section will show, it could be argued that the new prescription (e.g. self-assessment, portfolios, student-centred learning, evidence-based approaches, multiprofessional approaches, teamwork, etc.) contains many of the same ingredients as the old prescription (e.g. ENB, 1996). What is different,

however, is the implementation of a tighter national control over outcomes, the introduction of audit, clinical governance and effectiveness and the NSF for mental health. Whether that framework represents a more homogenised and coercive educational context depends on whether the competencies represent reality, or the fantasy of control (Stronach et al., 1994). But the intention, it is clear, is to extend control over programme structures, processes and outcomes.

We could further illustrate what we consider to be the contradictions (or turbulence) that inhabit the apparently smooth rationalities of the 'new' and the 'modern'. It may suffice, however, to point out that these contradictions constitute dilemmas for programme-writers that may not be reconstructed merely as questions of 'balance'. We believe the more functional definition of the MHN will have to supplant the more affective and personality-based version (at least on paper). Thus, identity has been redefined. It is generally held that evidence-based approaches should reinforce a scientific rationality. However, there is the danger that the notion becomes 'domesticated' into an anything-goes reformulation, like: *'evidence-based practice can be defined as knowledge, published research or as deriving from reflections on previous experience, which may include standards and protocols'* (UKCC, 1998: 25, our emphasis). The balance between theory and practice has been redefined (in theory). The need to develop, even in the pre-registration phase, the *'organisational and managerial skills required to lead a multi-disciplinary team'* has been asserted (ENB, 1999: 10) and shared learning provision emphasised as a way forward in a *New NHS* where *'... co-operation will replace competition'* (DoH, 1998: 2.16). We would argue, however, that the (apparently) smooth and rational surfaces of the reforming rhetoric – modernisation, partnership, self-regulation and competency – offer an all-encompassing rationality that conceals a number of significant contradictions. These may constitute dilemmas for programme funders and programme-writers as they devise, fund and run programmes: how do they address the paradoxes of policy?

The following section traces the next 'key translation point' which look at the ways programmes currently construct MHNs and imbue them with identity, role, values, and a penchant for teamworking and multiprofessionalism. The contrast between these extant programmes and the vision expressed by *Fitness for Practice* will be considered in the conclusion.

4.2 Analysing curriculum documents

This section concerns those institutional translations of national policy into specific programmes. It is concerned with the nature of the *'loose coupling'* (Cuban, 1990) between different levels of the health care/education delivery system. It addresses Research Aim 1: *'documentary analysis of the learning outcomes for mental health nursing in the CFP and Branch programme of DipHE and in a range of post-registration programmes'* (project brief, 2.2.1). Such an analysis of the various curricula in our sample will enable us to address the following questions:

- what implicit and explicit professional and educational models are inherent in the learning outcomes?
- how have these models been translated into specific pedagogics, curricula, learning opportunities, standards and assessment procedures?
- what differences or shifts in meaning are apparent within and between the learning outcomes at the different educational levels (overall curriculum, foundation, branch, placement, etc.)?

Out of the 31 educational institutions who were approached for their curriculum documents, 16 institutions responded positively. It became apparent that many institutions were reluctant to provide us with their documents, mainly because:

- in the competitive market system in higher education (HE), documents are seen as intellectual property which should not be made available to researchers in HE who could be regarded as competitors

- the documents were felt to be out of date and no longer representative of current practice
- colleges claimed that they had been bombarded by requests from researchers and found it costly and time-consuming to meet such requests.

4.2.1 Elements of professional practice

We identified a number of common features in the documents we analysed, which were distilled into five elements of professional practice:

- individual/agency/person
- partnership/teamwork/interpersonal
- stages/progressions/pedagogies/generic goals
- social and nursing contexts
- professional characters.

Some categories and concepts are fairly standard because of statutory requirements, such as 'reflective practitioner', 'partnership' and 'autonomy'. Others are more malleable and, we believe, give individual character to the programmes. Here we deconstruct aspects of these curricula, approaching them as potentially distinctive narratives that characterise the mental health nursing role in different ways and contexts, as well as making different assumptions about how students may develop into that role. In this way, we will argue that notions of 'narrative', 'emplotment' and 'denouement' are all plausible ways of understanding the variety of curriculum stories that our sample of documents represent.

4.2.2 Element 1: Individual/agency/person

A cluster of features relate to the *patient as an individual* – a *'unique'* individual (A: 10; M: 1; H: 1) to be understood in her/his psychological, emotional, social and spiritual entirety. *'The individuality of every human being regardless of cultural or social background must remain implicit within any nurse-patient encounter'* (B: 5). The documents vary in emphasis in terms of how holistically the patient is presented, although holism is core vocabulary in most accounts. For these curriculum theorists, therefore, practice must be client-centred. It appears that the more curricula foreground the client in this way, the more likely it is that they will also stress related notions of patient empowerment as a model for professional practice and a product of reflective practice.

Programmes vary considerably in terms of how the nurse is represented. While there is a shared core description, for example: *'autonomous, accountable and reflective practitioner'* (E: 66), some lay greater stress on the need to *'develop a personal philosophy'* (K: 12), *'evolve a personal agenda'* (E: 70), or to achieve *'a high degree of self-awareness'* (K: 32). Perhaps the most radical of these inner-directed rationales places an insistent accent on the nurse as self: *'help students to explore their own life and experiences within a social, cultural and political context'* (B: 60; also p. 34: *'It is essential that in order to care and understand the needs of others that they develop their understanding of themselves as individuals'*). Similarly, there can be an emphasis on the *'essential use of the self'* in engaging with patients and with the role (M: 170), or the *'intentional and conscious use of the self'* (N: 35).

There is often a strongly proactive notion of nurses as *'sophisticated change agents'* (D: 282). Such definitions relate, implicitly at least, to philosophical positions. For example, we hear an echo of a Heideggerian or existentialist view in this account of professional identity: *'the desire or decision to be someone, for example a teacher or a parent, involves a commitment to practically engage in contexts which are socially constructed settings for these modes of being'* (B: 122) (original emphasis).

On occasions, these concerns appear to remain rhetorical in relation to the written curriculum, but in some curricula they feature quite prominently in specific modules: *'developing yourself: motivation, reflection, counselling, interpersonal skills, managing change'* (L: 26). Such curricula tend to express nurse qualities in humanistic rather than role-focused terms: for example, *'open-mindedness, wholeheartedness and responsibility'* (L: 10).

Other accounts emphasise the role rather than the self, offering more outer-directed rationales for the role, e.g. *'adaptive, open-minded, enquiring, reflective, problem-solving, politically and environmentally aware'* (I: 3.2.1). Such programmes tend to stress the notion of 'competencies', as in one curriculum document appendix where 52 core skills are identified, all of which implied the autonomy and competence of the individual practitioner. It is worth noting that none of these competencies addressed teamworking and multiprofessional practice. The more self-orientated programmes tend also to foreground the role of reflective practice, offering, in one instance, a two-day workshop and expressing within the curriculum more of an emphasis on process rather than content.

Both the inner-directed and the outer-directed models tended to represent and stress the notion of 'agency' as a question of problem-solving. There was an implicit continuum running from such responses as creative and innovative, as opposed to adaptive and coping in nature. For example:

> *'It is a requirement of all health care practitioners to be innovative in offering creative responses to the rapidly changing pattern of health care demands.'* (G: 18)
>
> *'Learning is student-centred in order to facilitate the development of such skills and qualities as critical analysis, problem-solving, decision-making and creativity.'* (A: 16)
>
> *'Structured reflection and problem-solving, focusing upon specific issues.'* (B: 47)
>
> *'... ability to cope with uncertainty and change.'* (K: 31)

There was an almost universal insistence on *endemic change* as the norm of professional practice. The goal was comprehensively expressed as:

> *'... a competent, accountable practitioner who is enquiring, flexible, innovative and proactive, a potential agent for change who thinks critically, is able to practise in a rapidly changing environment and is able to take responsibility for his or her lifelong professional development.'* (M: 2)

We believe there is a strong tendency for programme proposals to be generally over-optimistic in regard to what may be achieved if their proposals are adequately realised: *'Thus the skills of lifelong learning will be achieved empowering the new practitioner to reach their full potential as a professional nurse'* (G: 15). Similarly: *'Demonstrate how staff development strategies can be used to maintain a responsive and flexible service that meets the needs of clients and their families'* (L: 74). It could be argued that this genre creates a view that education's reach is infinite.

Discussion of Element 1

This continuum, from the self-based or inner-directed to the role-based or outer-directed version of the job, seems applicable across most of the curriculum data we have examined. It appears to be variously related to the precise curriculum content in CFP and branch modules. In Jamous and Peloille's (1970) terms the inner-directed version could create a greater degree of role 'indetermination'. From our fieldwork we found that it also built a bigger gap between the educationally expressed ideal of the nursing role and the realities experienced on placement, or first appointment. This may point not to a theory-practice gap so much as an ideal-real division. This prompts the question: What are the costs and benefits of such routine utopianism? Such an (heroic?) emplotment of the professional in an idealised curriculum is quite common in

education and training provision (Stronach et al., 1994). In Scottish initial teacher education, for example, Stronach et al. argued that *'super performance'* is promised via an improbable offer of competencies: *'the assumption that somehow such a competence-based reform is likely to have far-reaching consequences for the quality of Scottish teaching, the nature of institutional teacher training, the autonomy of the profession.'* (1994: 131). In addition, Winter points out that initial training may envisage the *'professional-as-hero'* (or heroine): *'... the hero only just triumphs, by means of the "arduous journey"'* through the series of *'dangerous confrontations'* (on the street, in court, in the lab) *'with the forces of error or injustice by which professional work is always threatened'* (Winter, 1987: 99).

We would argue that there is often little indication of how the curriculum would achieve such an emphasis, whether inner-directed or outer-directed. That is, the rhetoric of aims and ideals does not appear to be translated in obvious ways into specific modular content or pedagogic process. We found that the connection between the overall curriculum rationale and specific modules looked tenuous in most of the programmes we scrutinised. An element of 'loose coupling' is often typical in such disjunctures and may be desirable in that it permits each level to have some ownership of their educational input. However, on the basis both of the documentary analysis and the case study data, we would judge that the disjuncture might best be characterised as 'de-coupled' in some cases. Questions that need to be raised in terms of future provision include:

- what is the quality of liaison between overall programme designers and specific module writers?
- how are 'philosophies', or educational and curricular models shared?
- how do students experience continuity and difference between the different components of the programme, in relation to their emerging overall 'identity' as MHNs?

We address these questions later in the report. In our view they are important questions for future programme writers. They also exemplify the sorts of emerging concerns that we carried forward into the case study phase of the research.

4.2.3 Element 2: Partnership/teamwork/interpersonal

Whereas the first element looked at the 'personal', this one depicts the characterisation of the 'interpersonal'. Here, we note that 'partnership' is part of the core vocabulary as is 'teamwork'. A number of partnerships are envisaged, such as the relationship between the client/practitioner/family or between professional liaisons within cross-disciplinary teams.

The first partnership was the relationship between the professional and the patient/client: *'... in partnership with the patient or client to empower them and facilitate autonomy'* (M: 1)

This was less often invoked than the partnership within the multiprofessional multi-agency team:

> *'... undertake activities which enable the student to be part of the multi-disciplinary team.'* (B: 47)
>
> *'... cross-disciplinary teamworking.'* (D: 151; see also D: 155-6)
>
> *'... deliver a refined presentation within the multi-disciplinary organisation.'* (M: 149)
>
> *'Much of the work of nurses demands negotiation and collaboration with colleagues from a variety of disciplines such as medicine, physiotherapy, social work, business and finance who are educated at Degree level.'* (C: 3)
>
> *'... to develop the skills required to work in multi-disciplinary teams across professional boundaries and in extended networks.'* (C: 3)

'It is essential that we allow nurses the opportunity to study at the same level to increase their confidence and negotiating power.' (C: 6)

An underlying concern was for equity within these relations, with the implication that nurses were often the deferential partner in role relationships; instead they should be *'able to participate on an equal basis in learning decision-making'* (M: 4). We feel it was generally assumed that teamworking was a growing demand on the nurse and especially for nurses within, for example, the mental health branch: *'... nurses who will be able to work in partnership with clients, carers and, potentially, communities involving them in their care and its evaluation'* (M: 4).

The frequency and apparent salience of these multidisciplinary references varied, as did its location within the branch or core. It was not uncommon, however, for teamworking outcomes to be unaccompanied by anything obviously relevant in the module content:

'To produce effective members of Primary Health Care Teams.' (N: 57)

'To involve other members of the inter-disciplinary team in the process of implementing research findings pre and post operatively.' (N: 147)

In addition, some programmes offer their pedagogy as a model for subsequent professional practice and, therefore, stress that over the programme teacher/learner relationships should evolve towards the student-centred, becoming mentoring relationships. Such 'partnership' approaches tend to be represented visually (i.e. diagrammatically) as interactive equal exchanges – the overlapping circle was a favoured symbol.

For example, document 'I' overlaps three circles representing the academic, the practicum and the person, identifying the core intersection as *'praxis'* (I: 20). In another example, the programme design began with the self (Year 1), expanded to take in the self and others (Year 2), with teams and organisations being addressed in Year 3. However, we found that the specific allocation of modules to these 'stages' did not always seem to conform to that rationale (M: 2).

Some programmes, such as forensic health care, appeared to need to emphasise multiprofessional and multi-agency approaches more than others because of the perceived nature of the professional work involved. In general, however, these themes do not seem to be prominent in the curricula we have examined. Nor do they seem (in so far as the programme outlines and readings reveal) to address the problematics of 'partnership'. The purpose of partnership is most often described in terms of empowerment: *'to empower the client carer or student'* (E: 26). Note, however, what, to us, is an interesting clash of status and collaboration implicit in document 'C' above – the concept of *'negotiating power'* as a kind of professional cultural capital. This is one of the very few indications that partnerships involve problematic exchanges of knowledge, authority and status.

We believe there is also a tendency to run 'autonomy' and 'partnership' unproblematically alongside each other in these documents, as in this example: *'Act independently within a multi-disciplinary multi-agency setting'* (E: 18). Other programmes, however, at least had a theory of what it took to make multidisciplinary accommodations of autonomy and partnership work: *'In teamwork and collaborative work, it is important for each professional to retain certain unique areas of skill and knowledge in order to maintain a clear identity, while sharing the remaining aspects with others'* (I: 4).

Discussion of Element 2

If there is a clear continuum in this area, it runs from the individually-orientated programme to an emphasis on collective action with a range of partners. Often the rhetoric on 'partnership' overlapped with implicit or explicit models of what ought to count as professional work (*'... in partnership with the patient or client to empower them and facilitate autonomy'* M: 1) and it was sometimes unclear what, in practice, was meant by these claims. Either of these poles (individual/collective) could be characterised as high in 'indetermination', although the collective

model tended to imply a stakeholder model of co-operation in which partnership had to be a matter of negotiation between the contracting parties. But one reading of the sub-text is that partnership was always something of a power-play in which the curriculum designers had in mind the advancement of the self-esteem and status of nurses in relation to other specialist health workers and, in particular, the doctors.

We believe a contradiction exists in most 'emplotments' of the MHN in envisaged interactions with colleagues in other disciplines. On one hand, the programmes talk of equality and its relatively unproblematic introduction via notions like autonomy, partnership, networks and interdependence. On the other hand, the hierarchic inferiority of the nurse is often implied either in terms of work hierarchy, personal confidence or educational standards. One focus group member was scathing about such appeals to equality, pointing to the realities of pay comparisons. We might wonder, then, whether a structured inferiority clashes with a rhetorical equality and raises again the dilemma of the 'ideal' curriculum, that is, the extent to which a training curriculum ought to entrench the aspirations of a profession, as well as its necessary preparations.

A similar contradiction exists in many curriculum documents between the desire for 'autonomy' and the need for 'collaboration' without indicating the tensions between these two aims and the dilemmas in terms of role-sharing, generic practice or core competencies. Empowerment is an equally slippery term (Rappaport, 1981) as, indeed, is the notion of *'partnership'* (Bratman, 1992). Rappaport argues that *'empowerment is an end-of-progressivism notion that ignores the possibility that a variety of contradictory solutions will necessarily emerge'* (1981: 91) and that we need to consider social interventions in more plural and discrepant ways. Rappaport also attributes wild policy swings to this sort of forcing of singular solutions. There are tensions, therefore, within the mental health nursing curriculum narratives that need to be acknowledged, even if they cannot be resolved. Although clearly the emphasis on self-esteem, confidence and higher levels of education in these professional prescriptions indicate that the nurse is embedded in a fairly singular 'recovery narrative'.

4.2.4 Element 3: Stages/progressions/pedagogies/generic goals

All programmes offered a staged learning process of one kind or another:

> *'... recognising that at the beginning of the course the student will be more reliant on a teacher-centred approach, moving progressively throughout the programme towards student-centred strategies.'* (G: 15)

This transition was present in most programmes, although more prominent in some than in others.

In addition to the distribution of responsibilities in the learning contexts of the student, there was also a concern for the linear, or stage-based, development of the practitioner as a developing professional (e.g. often Benner, A: 11, D). This was variously represented in pedagogic/andragogic terms, teacher-centred to student-centred evolutions and/or, in terms of Bloom's taxonomy of cognitive development, and usually referred to the arguably inadequate experiential taxonomy of Steinaker and Bell. Somewhat similarly, but more unusually, the stages could be seen as intellectual and/or ethical as in the invocation of Perry's model of increasing complexity or Goodman's taxonomy of differing levels of reflection. A more empirically grounded approach to curriculum construction (in theory) was to invoke a 'situational analysis', out of which key factors in the internal and external environment could be identified and incorporated in the curriculum design (drawing on Skilbeck (1984) for example).

The most radically 'equal' partnership in terms of authority relations between learner and teacher offered the concept of *'co-scholarship'* to characterise the teaching/learning environment (I: 12, doc. 2). In addition, theorists as various as Peplau, Habermas, Bloom, Friere and Lawton were invoked in support of the programme design, as well as works directly

addressed to nursing education. For example, *'Bloom's taxonomy has been utilised to determine the knowledge and skills required of Level 1 and Level 2 accreditation of learning.'* (B: 218). These citations often had a legitimating air to them, which led us to be somewhat cynical about whether programme writers were merely touching base with Board scrutineers: *'The above along with the evaluation process are wholly congruent with the recommendations of the ACE project (Phillips et al, 1994) which informed the construction of the assessment process ...'* (G: 43).

We occasionally felt that these theory-based prescriptions were reminiscent of a medical model of educational knowledge and curriculum prescription, as in this example, which was founded on Christensen's model *'for planning in an uncertain environment'*:

> *'Peplau as a professional influence on structuring the programme and its contents*
>
> *Ausubel to shape the assessment methodologies relating to theory*
>
> *Steinaker and Bell impacting on assessment of clinical practice*
>
> *Christensen to ensure a suitable balance between innovation and stability*
>
> *Norman et al to provide an emphasis on self-directed and problem-solving learning formats and new approaches to models of care.'* (G: 11)

One could argue that such a cocktail of theories is, itself, a multiprofessional team, but that a coherent programme rationale was less likely to emerge.

Such rationales also claimed to close the theory-practice gap through processes of consultation as well as cycles and stages of involvement: *'the potential for any theory-practice divide will be obviated by service and user colleagues contributing to contents selection and sequencing, providing input into the delivery of taught material, participating in student support and assisting in student assessment'* (G: 9). This strategy of programme development was strongly emphasised in some programme rationales (e.g. N).

Discussion of Element 3

These stages comprise a number of different dimensions, including:

- maturation (pedagogy/andragogy)
- intellectual development (e.g. Bloomian hierarchies)
- ethical complexity (e.g. Krathwhol, Perry)
- professional developmental stages (e.g. Benner)
- self-actualisation growth (e.g. Rogers)
- situational analysis (e.g. Skilbeck).

It was not clear to us how these different transitions could easily be reconciled with each other or be brought about in a programme dominated by a modular structure and yet which claimed to achieve *'seamless transition'* (e.g. from CFP to Branch, M: 7). However, the realisation of these stages would be incorporated into 'indeterminate' aspects of the definition of the role – emphasising personal and professional discretion and situated decision-making. Nor was it obvious how such progressions and stages could be married to the rationales for research-based or evidence-based knowledge. The 'research module' content tends to suggest that research knowledge comprised a preliminary overview of research approaches or paradigms, with, in our view, a slightly optimistic assumption as to what such programmes might achieve: *'able to prepare research proposals and conduct an independent research project'* (M); *'History of ideas/development of Western thought'* (M: 7); address the *'focal shift of nursing and midwifery to a research-based profession'* (N: 17).

The effects of competitive bidding on curriculum development are also worth considering. It could be said that programme writers have to simultaneously read the mind of the UKCC and/or the Board, put together an account that will anticipate their wants, sell that successfully to the programme-funding organisation and offer a deliverable programme internally. It would not be surprising if there were tensions in these various aims: the 'information booklet' could become confused with the 'sales brochure'. Again, this is an aspect of the 'coupling' mechanism between policy and curriculum, and indicates that the problem of coupling is not just a problem along the tight/loose continuum, it is also a conflict between specification and persuasion. Curriculum documents, then, do much more than merely document. They seek to make a good marriage.

4.2.5 Element 4: Social and nursing contexts

In the curriculum documents, we felt that there was a clear desire to contextualise the job in terms of the client *'located within the changing context of contemporary society and culture'* (A: 11); *'taking account of the social, cultural and health needs of the individual'* (B: 47). The theme of a changing context and job definition was powerful. *'The practice of Nursing, Midwifery and Health Visiting takes place in an environment of constant change'* (N: 1). For this reason, many curricula stressed the need to *'enable the students to reflect upon the interplay between moral and professional issues relating to their area of nursing practice and health care in general'* (L: 58). This kind of ongoing responsiveness was deemed the *'interactive curriculum'* (M: 9).

The most contextualised curriculum theory centred itself on the notion of 'uncertainty' and offered a design that claimed to deal with it based on Christensen. Those things that were 'agreed' but 'not known', or 'known' but 'not agreed' were represented in a four-box diagram – rather like a Johari window on the world, as opposed to the self. This became the foundational point for curriculum design: *'The second two quadrants B and C have an element of ambiguity and therefore require creative, flexible and ultimately innovative but consensual approaches'* (C: 11).

All documents made mention of changing contexts, both social and professional, although again the emphasis varied, with programme K perhaps the most insistent, since it offered eight *'change demands'* including: *'the need for a theoretical framework to integrate nursing practice, research and education'* (K: 5), via a *'living'* curriculum (K: 7). In general, teamworking and multidisciplinary practice were held to be central features of the changing environment, and, therefore, a change in the role rather than an addition to it. However, we felt the centrality of that redefinition was not always acknowledged in the modular provision.

Discussion of Element 4

There seems to be a lack of correspondence between nursing situations as envisaged in education and in policy documents and nursing situations as they exist in practice. There is a tendency for curricula, perhaps, to take responsibility for more than they seem realistically able to deliver. For example, there is a need *'for MHNs to develop networks and partnerships with other professionals to ensure effective care'* (L: 2); *'The current White Paper ... reflects the vision of a health service where care provision is of the highest standard ... The decision-making role of nurses will be further enhanced'* (L: 2).

Could it be that the bidding process engenders the development of over-ambitious curricula? Such programmes can tend to promise more than they can deliver, often in a voluntaristic move that obscures structural problems. Specifically in relation to teamwork issues, it leads to a presentation of a language prefaced on consensus rather than conflict, whose solutions (e.g. 'good communications') are either tautologous or anodyne.

We found many idealistic statements in the curriculum documents. These statements are often reported first as systemic visions (e.g. 'highest standard') and then a curriculum proposal is put forward which addresses this goal and then, in unacknowledged utopianism, promises that education (initial or continuing) will ensure its realisation. What these visions do not make

clear, however, is how the student nurse is to experience realities of care that remain only visions or, indeed, sustain allegiance to such idealistic goals in the face of a practical experience that may negate many of these claims. This points to the need to study very carefully the sorts of practical adjustments to reality that students make in their extended encounters with practical nursing situations and actual nurses. What kind of experiential taxonomy/stage theory would those sorts of immersion in reality engender (Miller et al., 1999)? What sorts of occupational socialisation are students exposed to and how does it mesh or conflict with the version of nursing that their education suggests to them? In other words, what is the nature of their 'vernacular transition' into the realities of the professional role (McNally et al., 1994)? Perhaps the question that we ought to be addressing is: What level of necessary tension between the ideal and the real is productive for learning and motivation in mental health nursing, especially at pre-registration level?

4.2.6 Element 5: Professional characters

The overall professional character of these elements brings together the various aspects of identity, role, qualities, development in context and outcomes in a final denouement of the curriculum narrative. We identified four professional characters:

- nurse as reflective practitioner
- nurse as leader
- nurse as educator
- nurse as research- and evidence-based practitioner.

Nurse as reflective practitioner

Perhaps the most insistent theme throughout the documents was reflection on practice as a means to theory-practice integration and a realisation of the ideal in practical settings. (This last theme was clearly signalled in the case study data in references to 'education-led' professional practice.)

> *'To enable the student to investigate the introduction of nursing research into the clinical situation.'* (A: 44)
>
> *'Reflection and reflective skills now become an essential requisite to their personal and professional development.'* (B: 42)
>
> *'... ensure the integration of theory and practice.'* (D: 141)
>
> *'... demonstrate the ability to reflect on their practice, and develop the professional knowledge and skills in the light of this reflection.'* (G: 5)
>
> *'The extent to which children, people with learning disability and mental health problems are able to identify, articulate and meet their health needs will be explored through branch-specific reflective discussion and will be incorporated into the portfolio.'*
>
> *'Examine their own critical practice through the use of reflection.'* (L: 37)

We found that Schön was the most frequently invoked source for this rationale. At its most enthusiastic, the notions of reflection-in-practice and reflection-on-practice were directly personified in programme rationales (respectively as the practicum mentor and the academic tutor). The clinical supervisor was also identified as a pivotal role for developing reflective practitioners: *'... the skill of reflective practice. This will be developed through the development of the role of Clinical Supervisor ... through the use of Action Learning Groups, critical incident analysis, reflective diaries and the use of a portfolio'* (M: 15).

Nurse as leader

Picking up on the notion of the role (in advanced stages) as combining competence, modelling and education (D: 261), there is a stress on management and leadership qualities – *'the way in which these concepts can be applied in the context of teamworking within organisations from the private and public sectors'* (D: 155). Such leadership typically stressed 'empowerment' as a central guiding notion and facilitation as a means whereby 'partners' could achieve their goals, holistically envisaged (e.g. M, L: 9). As we saw earlier, the nurse is depicted as a professional equal and, therefore, imbued with both personal qualities and professional skills. In this part of the recovery narrative the nurse emerges as a respected equal.

Nurse as educator

This was not just a role specification for the more advanced programmes but also part of the redefinition of the role(s) as essentially educative of others, whether patients, carers, or health care assistants (HCAs). For example: *'In particular the programme aims to develop an ability to organise the work of the team and facilitate the learning process in others'* (A: 13); *'To introduce various approaches to the dissemination and implementation of research findings ...'* (C: 32). Such education had predictable goals: *'the essential feature of mental health nursing is the empowerment of the person with mental health problems and the creation of necessary conditions for the clients' growth and development'* (N: 16).

In addition, there was the issue of embedding the notion of lifelong learning in the professional. This was a universal theme, achievable through the success of andragogical approaches to the programme. There was also a recognition that teaching could be very much part of the nursing role: *'The major focus will require students to design, implement and evaluate appropriate teaching and learning experiences for a range of learners, including client groups, and to demonstrate both understanding and critical evaluation of the application of educational theory in that context'* (D: 188).

Nurse as research- and evidence-based practitioner

This was a thread running through most of the proposals and, seemingly, increasing in importance as the qualification becomes more advanced: *'students must show the ability to critically utilise research evidence to guide practice'* (C: 45). We felt one of the more radical intentions was programme D's rationale which involved a practice-based audit of needs, followed by a practical research strategy which when implemented would have consequences for everyday practice in the place of work: *'The Research module is considered to be a working document of use during and after the course and not simply a dissertation that will be bound and forgotten'* (D: 151). As noted earlier, however, most research modules were of a general introductory kind and it was difficult to see how in practice they would connect with research-based approaches to professional practice, particularly those envisaged by evidence-based research. The references to research-based practice often had a rather rhetorical quality, with programme readings making no reference to research-based or evidence-based sources and, instead, invoking familiar general methodologists like Bell – research still seemed to mean understanding in general methodological approaches in the quantitative and qualitative areas, rather than direct contact with research-based approaches to nursing or medicine more generally.

Discussion of Element 5

In the light of the above, it is possible to characterise the different kinds of programmes offered at pre- and post-registration levels. Our analysis suggests that they centre on six different story-lines which the programme writers have combined in different ways. These are all concerned, naturally, with the acquisition of relevant mental health experiences and knowledge, but they differ in how they embed that learning in values, pedagogical strategies, and philosophies of practice and education:

- reflection
- empowerment
- autonomy
- skill
- emancipation
- evidence.

To briefly illustrate, empowerment models tend to foreground statements like this: *'To encourage patient participation in decision-making, care planning and treatment in order to promote their individual autonomy and strengthen self-empowerment'* (C). On the other hand, the emancipatory model offers a greater priority to *'a process of caring and therapeutic intervention which focuses on the whole person and has its goal the preservation of humanity within the health care system'* (I), or the *'ability to acquire holistic, humanistic and confluent approaches to learning within a supportive, person-based teacher-learner relationship'* (J). Evidence-based models are more concerned with closely mapping knowledge on to experience: *'clearly relevant to the practice of the student'* (D), or *'expert knowledge supported by available research'*. The reflective strand can be represented by the following: *'contribute to the learning culture which facilitates creative thinking and leadership through fostering reflection, analysis and evaluation and enables the demonstration of a greater degree of confidence in the performance of roles'* (G), or *'to critically examine the concept of the professional role, role change, potential role conflict and strategies to cope with this'* (N).

In each case, the interaction of the nurse in relation to other professionals, care workers and users is plotted somewhat differently. The more 'humanistic' the story, the more likely that successful outcomes will be written in the language of personal values and qualities. The more evidence-based and technical the specification, the more likely that co-operation will be based on the rational allocation of roles in relation to different expertise. In these ways, different narratives of who nurses (really) are, contain within them varying prescriptions for teamwork, as well as assumptions about the distribution of authority and responsibility in implied contexts of work. Thus, even if there is a common language of 'partnership', it is translated in different ways when it is viewed in terms of the overall curriculum narrative.

4.3 Conclusions and issues

The programme documentation shows at least three tensions, between:

- competition and co-operation
- top-down programme design and bottom-up initiatives
- the insistently practice-related, holistic, developmental and empowering rhetorics of most of the curricula and the fact that they are all modularised and university-based.

4.3.1 Competition and co-operation

Programme rationales sometimes directly refer to the need *'to remain competitive'* (1: 6, second document). Our analysis has been hindered by a certain coyness in letting 'competitive tenders' into the public domain, even if anonymised. Such a closed economy in terms of curriculum design is clearly at odds with research-based or evidence-based approaches to professionalism, which are based on open access to any information for professional decision-making. Questions worth considering here might be: What are the costs and benefits of competitive tendering? What would research-based curriculum design look like if implemented in the above sense?

4.3.2 Top-down programme design and bottom-up initiatives

One view could be that programme structure is already determined by a mixture of university regulation and UKCC/Board prescription and that the best bits of these curricula should be united into a national curriculum for nurse training. Yet such a move would involve elements of self-contradiction. For example, the Board's Guidelines (1996) specify *'user and carer representation at all stages of curriculum development and management'* (1996: 6). The UKCC's Chief Executive/Registrar also notes:

> *'it is vital for the success of any regulatory system that it secures the ownership and active participation of those registered professionals whom it regulates and who fund its work'* (UKCC, 1997: 2)

It seems from the curricula surveyed that distinctive programmes have emerged (at least on paper) and that nursing educationalists feel that they add to the national specifications: *'All modules have been designed to reflect the course philosophy as well as meeting the UKCC's criteria'* (J: 4.4).

A central question here is whether a national curriculum would save the time and money spent devising a whole range of curriculum bids, or whether it would kill off the sorts of educational inquiry and debate directed at responding creatively to the changing educational needs of mental health student nurses. Experience in other professional arenas may be instructive. For example, in initial teacher education there is a national curriculum addressing curriculum and pedagogical approaches. As a result, the sorts of curriculum theorising that the nursing curricula typically cite are somewhat obsolete, since the Government decides the curriculum and, increasingly, how it ought to be taught – both in school and in HE. Clearly, HE is allowed to continue with its fantasies of autonomy – bids to run programmes continue to be 'personalised'. A further option would be to encourage schools/departments of nursing to greater rather than lesser diversity on the grounds that 'one size doesn't fit all' in mental health nursing. Whether the diversity that we have found in current programme provision is optimal or not, it is clear that conflicts and contradictions in their construction lead them into over-optimism that shades into fantasy in terms of their outcome claims. This fantasy of *'superperformance'* (Stronach et al. 1994) is common in initial, rather than in continuing, professional education and training and, we argue, results in the perception of damaging 'gaps' between the ideal and the real, between theory and practice.

4.3.3 Practice-related rhetorics and university-based curricula

The third tension is between what we consider to be the insistently practice-related, holistic, developmental and empowering rhetoric of most of the curricula and the fact that they are all modularised and university based. As one document noted, such provision is inherently prone to *'over assessment, poor integration and progression of key concepts'* (I: 6, second document). This is a matter to which we will return when considering the data from the case studies. These data allow us to acknowledge that where a curriculum takes place is also part of the curriculum and that some of the 'emotional distances' between HE and the clinical area are significant.

These three tensions complicate the relation between the policy level and the local development of curricula. We began by envisaging the connection, in Cuban's (1990) terms, as a kind of *'coupling'*. We complicated that notion by noting the marketised nature of the relation, subject to competition and confidentiality. As well as being a 'gap' it was a 'field of forces'. Adding to that there is the relocation of nurse education in HE, with all the pressures that brings to bear on aspects like 'shared learning' – for example, re-expressing a resource issue as a 'teamwork' benefit. Again, the politicised and pressured nature of the curriculum becomes apparent. Within that curriculum field a number of different narratives of MHN education have been constructed. Each story seeks to outline a convincing narrative that weaves in the policy imperatives while expressing its own values, aims and proposals for educational action.

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Our conclusion would be that teamwork issues must be seen as a sub-plot of the bigger story; they are a microcosm within the larger world of the curriculum and need to be read as part of that bigger world rather than examined separately.

4.4 Influence of this Aspect of the study on subsequent Aspects

The philosophical and theoretical implications of this analysis have been ongoing throughout the life of this study. After the initial analysis of the curricula, briefing notes were constructed for team members to help them to plan and focus their time in the field when undertaking the case studies. Below is an example of the briefing notes relating to one specific case study site.

Briefing notes for Case Study 4

The following documents from the educational institution in this case study site have been analysed:

- Advanced Diploma in Nursing Studies – CFP and Mental Health Branch (plus all the associated documents with this programme – portfolio of assessment documentation, practice booklets, staff CVs, student handbook)
- Care of the Mentally Disordered Offender ENB A71 incorporating ENB 956, BSc (Hons) Forensic Health Care Practice

Both programmes can be discussed together since they seemed to have a similar rationale. In fact this seems to be one of the best designed curricula (in terms of being well-argued, interestingly based and so on). The forensic documents in particular raised a lot of issues about their *'inter-professional approach to care from a multi-disciplinary team'*. Here are some things to think about in the field:

1. What are the 'unique' aspects of the role that each professional should retain? (*'... it is important for each professional to retain certain unique areas of skill and knowledge in order to maintain a clear identity, while sharing the remaining aspects with others.'*)
2. Has it turned out that (a) shared learning and (b) mixed groups have done much to shift attitudes, reduce stereotyping and *'professional protectionism'*?
3. Is there a tension between working towards an *autonomous* practitioner and the multidisciplinary teamworking aspect? Logically? Practically? Who is it resolved by?
4. There is a whole series of claims about teamworking made in the programme documentation. Are they defensible? Actually held by tutors and students?
   - Care given by groups is greater than the sum of individual care.
   - Rare skills are used more appropriately.
   - Teamworking encourages continuity of care.
   - Peer influence and informal learning within the group raise the standards of health and social care.
   - Team members have greater job satisfaction and are better able to cope with failure.
   - Teamwork co-ordinates preventive with curative work.
   - The development of the CPA with key worker and case management is more effective in teams.
   - A collaborative approach to the safe and appropriate care and management of the mentally disordered offender is needed for enhancing and ensuring the protection of the public.
5. Both documents are *empowerment* centred, and make an unusual claim to represent the three *'interests'* of knowledge identified by Habermas in his earlier writing – technical, practical and emancipatory. The key is to *'instigate empowerment based emancipatory practice'*. Is this realised? What are the implications for teamwork?
6. Are learning journals useful for their purpose (and as data)? The document refers to *'staged learning'*. Is there a 'best time' for introducing multidisciplinary issues and teamworking?

The briefing notes provided a direction for the person visiting the region from which these curriculum documents came. In addition, they provided the team with some specific curricular issues which we needed to address in the initial survey.

Further, the policy and implementation profiles we developed raised several tensions for us and numerous issues which we needed to pursue in the case study phase. Below is an example of these issues which was used as a starting point for our data collection and analysis in Aspect 2 (the focus groups) and Aspect 4 (the case studies).

Issues

1. What processes of consultation went into the construction of the curriculum? What influences were dominant and why? What is distinctive in general about your programme in contrast to others you know about? Is there a distinct professional model explicit or implicit in the programme rationale? (e.g. Schön, James) How well is that model translated into programme provision? How can its ideal features be summed up (e.g. autonomous practitioner/living theory of nursing etc.)? Do managers/tutors share a vision of that? Do they believe it to be realistic/utopian/whatever in relation to (a) pedagogic practice (b) practicum realities?
2. Is there a distinct educational model explicit or implicit in the programme rationale? (e.g. stages of learning, stages of socialisation, gradients towards student-centred, notions like 'co-scholarship' etc.). What theories are involved and how were they selected? How well are these models (a) shared among tutors (b) implemented in practice (c) congruent with the professional model (d) understood/agreed by mentors and other practitioners (e) able to influence professional practice and decision making? (Most of the above is applicable to aspects of pedagogy, curriculum and assessment.)
3. How successful are the learning partnerships between (a) tutors and students (b) tutors and placement supervisors (c) tutors and users/carers and voluntary agencies (d) students and placement personnel? To what extent do they have a bearing on effective performance and congruent education and training? How can these various linkages be characterised both in theory and in practice? Are there specific concepts that are employed to characterise the linkages? How is it envisaged that theory and practice will be integrated? How well does that turn out in practice?
4. How is the role of the nurse (as professional or as person) envisaged? Is it 'inner-directed' in terms of the development of the self as a person (e.g. perhaps reflective practitioner emphasis), or 'outer-directed' as professional work (e.g. skills, competencies)? Which of these roles apply and with what emphasis? Change agent/ problem solver/reflective practitioner/leader/educator/other? In what sorts of ways are these roles dealt with in educational terms? (e.g. tutor models the role, practitioner models the role, taught skills, special modules). What is the balance between education about the role (e.g. socio-economic contexts, nurse in society) as opposed to education for the role? (Might be technical versus critical versions of the role?) Is the balance about right? If not then what?
5. What is the role of the MHN within the team? How is an identity developed? What match or mismatch is there between the theory in relation to their 'contributive membership' and the reality of the role in practice?
6. How specifically is teamwork taught or 'caught' as part of the programme rationale and reality? What in theory and practice are taken to be the qualities and skills and experiences required for its development? Are there special concepts that are aimed at (e.g. 'negotiating power' turns up interestingly in one curricula, 'boundary management' in another)?

7. What impact have evidence-based or research-based approaches to professional practice had in theory or practice? Now or in the future? What problems and opportunities are anticipated?
8. Do respondents believe in the theories behind the construction of the professional and educational models? Is there a *de facto* national curriculum based on guidelines, or is programme construction by the institution a central part of (e.g.) ownership? Are there top-down and bottom-up issues here? What are the effects of competition/secrecy in terms of different institutions' programme construction? How would tutors, etc. like to see programme construction changing in the future?
9. Is the actual professional performance congruent with the educational learning outcomes and *vice-versa*? Are there inhibiting factors to the effective embedding of the 'model' (or theoretical? utopian?) outcomes in practice?

Findings from the exploration of these issues are reported in subsequent chapters.

5.1 Focus groups

The team attempted to recruit 12 members for each of the six focus groups (Education, Service professionals (i), (ii) and (iii), Voluntary agencies/user representatives, Service users and survivors). Seven members were recruited for all focus groups except Service professionals (iii), the multiprofessionals, where only five people attended.

Themes emerging from the initial analysis of the focus group data were used to develop the survey. For example, when constructing the service survey, quotes from the focus groups were specifically used in some questions. Themes which were similar in more than one focus group resulted in a similar, or the same, question being asked in more than one survey to enable comparisons to be made between the groups. Subsequent analysis of the focus group data provided significant issues and areas to be explored in the case studies.

5.1.1 Issues arising from the Educational focus group

Curriculum, pedagogy

The group seemed uncertain about the educational efficacy of any approach to teamworking, invoking Schön – you had to learn by doing it, not *'artificially'*. For example, one group member said, when emphasising the *'shitty'* aspects of the job, *'nothing teaches you how to deal with it except dealing with it'*. But she continued to say that the curriculum had to include the realities of the job. To what extent do the curriculum and classroom teaching discuss the realities of the *'shitty'* parts of the job?

There seemed to be a vision of university-based education as *'free-and-easy'*, *'cosy rhetoric'* and *'room to think'* whereas professional reality could be *'violent'*, *'aggressive'*, *'scary'* and full of intractable problems – individuals may *'spit in your face'*. To what extent is this reality for students? Does the separation of a 'clinical culture' and an 'educational culture' provide the students with the opportunity to challenge practice as well as develop a different sense of self?

How do educationalists resolve the fact that students arrive with different life experiences and educational backgrounds?

When the group was asked about the content of the curriculum some powerful responses were heard, *'What the hell was going on in practice which demands such high order levels of skills from its graduates?'* They felt only so much of the basics could be given on any programme, *'you fill in the gaps as you go along'* – *'the 100 years training'* aspect. These comments are contrary to those made in the Service focus group (students lack basic skills, etc.). Such contradictions were explored further in the case studies.

Group members resisted notions of who should 'lead' the curriculum. It should involve broad consultation with users and other carers – that was *'hugely important'*. It represented also *'the aspirations of the Government'* particularly as emphasis on accountability *'enshrined within this notion of protecting the public'*. One person felt *'The curriculum should be student led – they go out into practice and then come back and say what they need – it needs to be a flexible model'*. A problem was, however, *'clinical practice ought to be sure what it wants and it isn't'*. What evidence is there as to who is leading the curriculum?

The importance of role models both in education and practice was emphasised. Lecturers, whatever their background, were not practitioners: *'The role models they are looking for in the classroom aren't there. They are lecturers not MHNs. There is a claim they were MHNs in a previous time, but they are now lecturers in mental health.'* What constitutes a good role model?

There seemed some scepticism about *'transferable skills'*. Even content was problematic, there being a danger of *'overload'* in the curriculum, plus a need to recognise that it was *'knowledge to question practice'* that was needed, as well as skills.

Teamworking

Teamworking is determined in a number of ways, ranging from legislation to culture and salary to status, so we have to avoid making too many assumptions about what is possible.

We needed to examine teamworking which illustrated the tensions and inflexibilities of the situation and which portrayed the role in its complexity and difficulty, i.e. a skills-based approach would not address the 'contextualised' nature of teamworking.

Individuals commented that *'some tried and thought things through'*, others were *'dragged screaming into it'*, yet others would say *'yeah, let's take some risks'* – what do these statements mean?

Multiprofessional working

The group implied that multiprofessional work was covered in a session and an account of *'where they fit in'* was given. It seems that lecturers did suggest to students that they talk with multiprofessional workers on their placements to increase their knowledge in this area.

Group members commented that multiprofessional working could mean working closer together (i.e. in the same building). How are people defining terms and using language in relation to multiprofessional working? What does multiprofessional working look like in practice?

Group members did not seem very hopeful about the efficacy of strategies for multiprofessional education such as shared learning, pedagogy congruent with teamworking, teamworking skills, etc. Shared learning seemed more possible with some groups (such as SWs) than others, but not with doctors. (The latter were portrayed in elite terms, e.g. as having a higher intellectual/knowledge stock and happy to hold onto their key knowledge while sharing learning in more peripheral areas.) One group member said nurses had the most to lose from shared learning – what was meant by such a phrase?

Other issues

The nurse (professional role) was portrayed in research-based *open* terms, whereas the curriculum was *closed*. Again we saw evidence of competitive tendering making people secretive about the 'goods' they had for sale.

The curricular documents were labelled as *'flat documents'*, *'only see the light of day when they are presented to the National Board'*. It was argued that there are such radical differences between the paper and the practice that the curriculum, to a certain extent, was meaningless. This is important for our documentary analysis – radical differences between prescription and practice could make the documentary analysis pointless.

5.1.2 Issues arising from the User focus group

Some of the data from one particular participant were obviously contradictory (e.g. help/no help – *'they impose services on you ... forcing you to do things'*, *'I have to say ... they did me a good turn in many ways'*, ill/not ill – *'I refused to have what was called a nervous breakdown'*, *'terribly ill with a full-blown nervous breakdown'*). On what grounds can we attribute this data to separate themes? Is it data? The contradictions could be taken to exclude the data (for example, on medical grounds) or to include it (on the grounds that it represents an underlying and valid ambiguity in her response to care). Are the data of others in the group radically different? Do the data have a different kind of authenticity? What are the problems in general of 'user' data in studies of mental health effectiveness?

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We know that one group member, at least, was a counsellor. So we potentially have some leaky categories – part-patient, ex-user, professional ex-user, professional counsellor.

We also needed to think about the 'professional ex-user'. (Note: the use of this term in this report is not meant in a derogatory sense. The term is used in the field to refer to those ex-users who have become spokespersons for mental health services.) This notion connects with that of formulaic diagnoses that patients, in general, may feel obliged to offer. There was acknowledgement of loss of social/professional role and a shifting towards an extended role to compensate, such as becoming active in MIND, writing for the newsletter, training as a MIND advocate or counsellor. We were reminded of this when we heard comments in the focus group such as, *'They [the nurses] were really nice – I shouldn't be saying this'.*

It may be a form of legitimisation to become a professional user, and the main 'badge' for this is to have been in hospital and placed on a 'section', since this means the person is better able to represent the users' perspective meaningfully (Rogers and Pilgrim, 1991).

References to holism, the whole person, etc. came up, *'They [health care professionals] should start treating people as a whole'* (Service user).

> *'It was a fudge cake and of course all the house smelt of chocolate. He came in and she says, "Ooooh, that's nice, what is it?" and I said, "I'm baking a cake" and she turned round to the support worker and said, "Is that true?" Like there's no way I could possibly bake a cake because I've got a diagnosis of being mentally ill.'* (Service user)

Relationship with carers

The MHN is viewed in both good and bad lights. The group members used several words and phrases to describe what nurses should do:

- listen
- treat people as a whole person
- be patient
- be understanding
- be supportive
- confide in
- talk to
- care (caring)
- reassure
- be protective
- enable
- encourage the person to take risks.

Most of these are humanistic qualities which, with some variation in the language, echo both *Working in Partnership* (Butterworth, 1994) and *Pulling Together* (Sainsbury Centre, 1997), and many of the core skills of the MHN.

What MHNs were seen to be and do had some affinity with the above list, but several other words or phrases were used by group members:

- don't listen
- sit in the office playing cards on the computer
- act professionally

- don't discuss anything
- make their own judgements
- get sent out (to patients in the community)
- impose their ideas on you
- force medication on you (*'let's hold him down, let's inject him'*) and act like heroes afterwards
- don't represent patient view (*'My CPN didn't stand up for me'*).

Lutzen (1998) questions whether coercion, subtle or otherwise, is justified in psychiatric nursing practice. Is it possible that various levels of coercion are being used by the nurse (and other professionals)?

Do users and ex-users go through stages of affiliation/alienation with their nurses? *'I'd an SW who totally resented me', 'imposes services'* said another, but later commented *'I would not be here today if it wasn't for them'*. Do they, as a result, have different inclinations to scapegoat their 'helpers'?

SWs were felt to be *'more on the ball, nurses are not always'*. Generally, service users felt that a better rapport and relationship was formed with the SW and OT. Could this be because they help with more of the everyday realities such as food and shelter and finances?

Teams supposedly include the patient/user but this did not seem to be the case from the group members' stories. The student nurses were the 'heroes' according to the participants in this focus group. Some nurses on the other hand were seen as being *'quite different. I think they think they're consultant psychiatrists! ... They are given the bulk of the work but they like to show their power.'* (Service user).

It appears that support workers are valued because of the time they invest in the user, allowing a relationship to develop. *'My support worker [MIND] did far more than anyone else. I felt safe ...'*.

Care

A strong theme from these data was the ideal-cynical descent when participants were describing nursing and nursing care:

> *'I told a friend I was going into hospital and she said, "Ooh that will be a treat, you'll be mixing with the professional ones".'* (Service user)

> *'My daughter wanted to go into nursing and she said, "Mum, I don't think I have the qualifications" and I said, "Don't worry about that darlin'" and she went on and on about not getting the qualifications and I took her up to the office and I pointed at the senior staff nurse who was sitting playing cards at the computer while the patients were around ... it's a doddle you just sit there when you're qualified, that's what you do.'* (Service user)

Would these descents impact on teamworking – i.e. are they common across all groups, do they differ, etc., what are their implications for teamworking? What forms of feedback influence these professional 'careers' – between professionals, between professionals and users?

The humanistic aspects of nursing appear to be valued by the users and the coercive, but not the controlling aspects, something clearly recognised by Rogers, Pilgrim and Lacey (1993) for MIND. Users regard talking therapies as preferable to physical intervention (drugs, therapies, etc.). Indeed, one respondent even stated that there is no need for nurses unless they opt for the patient-enabling role over the patient-control role.

Users talked about student nurses in positive tones. What happens to the student after qualifying? Edwards (1995) suggests that student MHNs are increasingly incorporated into the dominant culture and away from the ideas they once shared with users. We needed to explore the 'dominant forces' of the culture.

5.1.3 Issues arising from Service focus group

Development of mental health nursing

Most group members had been in mental health nursing since the late 1960s/early 1970s, and therefore knew of the changes to culture and care which have occurred in mental health services.

Major changes included the increase in drug- and alcohol-related mental illness, *'at least 60%'* of clients on one ward mentioned. Also, clients suffering from mental illness tend to be younger. These changes require nurses who trained some time ago to acquire new skills and training in areas such as drug-related aggression. This is described as representing a challenge to the traditionally trained. The old tactic of *'when you used to have an aggressive patient you had a room to lock them up in'* is no longer perceived as valid. Nurses now will *'sit and talk to patients and give them more time'*. In this study, we needed to be alert to the ways in which individuals have/have not responded to contextual changes.

Such changes in the culture were seen by the nurses in a positive light – patients are treated better with more rights and dignities and also have more responsibilities. They believed that *'we've gone a long way'*. How was evidence of this revealed in the field?

Education and training

There were conflicting views about the 'old' and 'new' style of training. The worrying observation was also made that by not adequately preparing students for what mental health nursing is like, newly qualified staff drop out since *'the reality never meets the expectations'*. This added to the fact that there was already a shortfall on the wards caused by the DipHE education. Is the training developing critical, reflective practitioners? *'You can only be critical when you've got the knowledge.'* A manager commented: *'I mark knowledge with experience. Knowledge is otherwise limited'*.

It was felt that DipHE students were taught more about managing than providing care – with some nurses saying that *'nobody wants to be a care-giver anymore'*. This shift away from the traditional skills and training of nurses was blamed on senior educators and nurse leaders within the Board and the UKCC who, it was felt, had made the mistake of *'[assuming] that "professional identity" meant academic qualifications ... rather than understanding responsibilities'*. The loss of clinical lecturers was also regretted. Lecturers in HE were not felt to be clinically competent – what implications does this have for nurse education and training and for the nursing profession in general?

The nurses were disillusioned about the content of post-basic training. They would prefer to see training which will update clinical skills, particularly as the client group has changed considerably over recent years. *'We need more courses dealing with the problems of today'*, *'[training] is not keeping up to speed with the skills that we need on a ward'*, *'help to maintain positive images of client groups'*, *'the emphasis needs to be on people's problems as opposed to how to manage the whole ward'*.

Problems were identified relating to time and money and post-basic education and training. The introduction of the UKCC's Standards for Education and Practice following Registration (PREP) meant that all nurses have to undertake the equivalent of five study days every three years. The evidence from this focus group suggests that this statutory requirement in practice was meaningless, with staff putting themselves down for anything in order to fulfil the requirement.

To this group, education appears to be out of touch with practice and the finished product is not what is required in service. Further, experience is felt to be the cornerstone of practice.

The MHN

Participants listed desirable qualities for an MHN: positive attitude, motivated, willing, a good personality, a person with the capacity to develop, intuitive qualities, qualities you often can't teach, team player, able to communicate, social skills and compassion. The knowledge base of nurses was considered important because of their role in instructing untrained staff *'in the job to be done'*. The need for nurses to have research skills and for nurses to be a role model was also mentioned. It would appear that the qualities considered to be most important in MHNs are almost irrespective of the training and education they may have undertaken.

Activities performed by MHNs were considered to include listening, risk assessment, psycho-social intervention (PSI), anxiety management, managing, maximising the quality of life, giving hands-on care, co-ordinating care, liaising, delegating and facilitating. One person stated that the only role which MHNs can call their own is giving injections (*'doing depots'*), since all the others can be done by other staff. Since the advent of the DipHE, even this may not be safe, as one nurse commented, *'You can find a staff nurse who hasn't given an injection'*.

There was a hint that risk assessment generates a notion of autonomy which gives full responsibility for actions taken, without giving opportunity for any real decision making. Nurses felt that it was more an exercise in scape-goating than an attempt to facilitate a quality service.

Group members raised opposing views of the MHN's role as either all inclusive and expanding or as encroached on by others and contracting. Health care assistants (HCAs) have usurped the role of the nurse in providing hands-on care, so what is there left for the nurse to do? Opposing this was the view that the role of the nurse has *'become immense'*. Other voices spoke of *'a lot of grey areas, a lot of crossing boundaries'*. The role of the MHN is not clear-cut or easily and consistently defined.

MDT relationships

Feelings of alienation, antagonism and cynicism were evident, particularly about the nurses' relationships with other professionals such as SWs and doctors, and when making their frequent references to resources. These attitudes may stem from frustration arising from nurses' traditionally submissive role and from a lack of control and input into the wide-ranging changes to which mental health care has been subjected over recent decades. Like the educators, the nurses appear to believe that while nurses continue to have a fairly low status, doctors and SWs have *'a fairly elite view of themselves'*. They speak of a political agenda: *'everyone [wanting] their pound of flesh when something goes wrong'*, *'there are a lot of splits in health, even within our trust'*. SWs were perceived as having *'power because they've got the money'* – which created much hostility.

Nurses and SWs are portrayed by the nurses as being two separate teams, tugging the rope of mental health care in opposing directions. The participants accuse SWs of having *'no understanding of mental health care'*. The nurses believe that although they make every effort to *'talk at their level, the SWs will not give and help you to help them understand'*. A major problem was the different belief systems adhered to by different professional groups arising from different philosophies about health and social care.

Although the multiprofessional team was not felt to be a reality, it was stated that *'when the team breaks down that's when disasters happen'*. This may be more a breakdown in communication channels than the disintegration of a team. Most of the views regarding MDTs in this group were in contrast to much of the literature, such as Higgins et al. (1996) or Onyett and Ford (1996), where it was considered that community teams could work well if there is collaboration in planning and provision.

The professionals felt the service users tended to feel they had a better rapport with SWs or OTs, possibly because they help with the practical problems, which the multiprofessional focus group identified as being a major contributing factor in mental health problems.

Unqualified staff were clearly seen as important *'Unqualified staff have always been your eyes and ears and even more so now'*. They were seen as skilled in observation and in carrying out planned care, the *'hands on'* seen as a MHN's role, although the phrase for some MHNs constituted *'dirty work'*.

Policy

Mental health was seen to have no clear definition of where it is going. The Board was seen as powerless and out of touch, as was the UKCC with the PREP requirements, *'It's throwing peanuts. Massive investment is required'*. The agenda for community care left the inpatient area as a *forgotten agenda* with the Sainsbury Commission even holding conferences on the subject.

The Mental Health Act was viewed as weak and inappropriate. Section 25 (DoH, 1995) was considered to only burden the CPN with models of care that didn't work in the community and to put the MHN back in the role of custodian.

The CPA was seen to be led by health but the funds were soaked up by social service provision and needs-led care was not being seen to happen.

5.1.4 Issues arising from the Multiprofessional focus group

The role of the MHN

Eroded due to:

- *Displacement.* The shift from hospital to community meant nurses had to make a *'transition from custodians to enablers'*. There was agreement that nurses *'who had been hospital based found it hard to come into the community'*.
- *Disenchantment* with the medical model of health. *'Most MHNs come out of training with a medical view of, for instance, schizophrenia.'*
- *Disillusionment* of nurses due to changes in the provision of mental health care and the situations in which nurses find themselves once they qualify. *'When nurses qualify, they get the innovation and enthusiasm beaten out of them.'* The changed culture and altered needs of those with mental illness have led to nurses' traditional skills no longer being relevant. *'A lot of nurses didn't feel they had any skills or influence to offer people with severe mental illness.'*

Strait-jacketed by ambiguous responsibility:

- *Increased responsibility* arising from the external forces of government, shortages of resources, organisational structure, managerial directives and other professional groups.
- *Unfamiliar responsibility.* Traditionally, doctors decreed the care to be given and the nurses carried out that care, *'... an older model when it was very much about the doctors and nurses together'*. Nurses are unused to taking sole responsibility for assessing and defining the needs of clients.
- *Discarded responsibility.* Many of the additional responsibilities which nurses now have were discarded by other professional groups, notably doctors. They are doing *'a lot more jobs junior doctors would traditionally have done'*.
- *Powerless responsibility.* There is no accompanying freedom and power to go with their extra responsibilities. *'They're there to bed manage and fill in forms.'*

- *Unsupported responsibility.* Nurses taking up responsibility for assessing people in their homes do not feel they have had adequate training for it. *'They're asking now in the team, can they have some for training for that.'* There is a fear that they will not be supported if anything were to go wrong. *'They feel they're scapegoats.'* Why might nurses feel they are unsupported even by colleagues from within their own profession? The same doesn't appear to be true for doctors, for example, who are perceived as closing ranks when something goes wrong.

Contradictory views of the MHN's role:

Despite, at times, describing the role of the MHN in glowing terms (*'they have a very valuable role'*, *'I see it in a very positive light'*), suspicion is aroused that some of the multiprofessional workers in the group may consider nurses as not quite up to the challenge of caring for the mentally ill today, or feel that the role they have to play is unclear. Transferring from working within hospitals to communities is described as *'a huge quantum leap for institutional nurses who've been there for donkeys years'* and are *'sometimes more institutionalised than the patients'*.

Group members speak of the nurses as having *'developed valuable skills through training and experience'* and as *'bringing clinical skills and experience of working on wards which [other professions] don't have'* and yet elsewhere state that nurses are not able to use these unique skills. *'They don't feel they can do their nursing anymore ... they do still have clinical skills but they've forgotten or don't use them.'* If the nurse's only unique contribution to mental health care is in the form of clinical skills and ward experience which is now largely obsolete, what role is there left for the MHN to fulfil?

Generic:

It would appear that many of the skills which are attributed to MHNs: *'skills ... of recognising early warning signs ... picking up when people are starting to relapse'* could, in fact, be performed by anyone with certain personality traits and inherent skills. The SW present perceived her profession as fulfilling a very similar role to that of nurses, *'in many ways the roles are very similar'*. She believed that *'SWs are discouraged from therapeutic skills'* which gives the impression of false role boundaries being enforced.

Multiprofessional teamworking

There is a lack of a clear vision for multiprofessional teamworking which means that *'we're stumbling through changes almost'*. In mental health care generally there is believed to be a lack of an overall strategy: *'it's crisis management. Sticking plaster management'*. If a team happened to work well it was more due to luck than planning: *'too often teams only work because of the personal characteristics of those in the team, not because of the structure of the team'*.

Having already discredited the medical model, it appears that the multiprofessional teamwork model may be failing too. The group identify that *'suicide is a social not a health problem'* and they feel frustrated in their efforts to tackle social problems leading to mental ill health. Their frustrations arise from a number of sources.

- Lack of resources. A project was described in which nurses were attached to GP surgeries and were doing *'masses'* of good work, but they *'didn't have enough resources to help their clients'*.
- Lack of power to influence and change the wider circumstances of someone's life: *'you can't change the living environment'*.
- Lack of training. GPs in particular were identified as lacking the knowledge and training to improve clients' mental wellbeing. They were believed to be *'unaware of voluntary services such as bereavement counselling'*; constrained by time; prescribed inappropriately despite the fact that *'there's no evidence to suggest that anything you do for these people makes it better'*.

Although generally positive about their perceptions and experiences of multiprofessional teamworking, a closer inspection reveals possible divisions and hidden agendas. Some divisions have always existed. *'Psychology and psychiatry have never got on'*, *'consultants don't like us [SWs]'*. Although the medical/everyone else division seems to be the sharpest divide, it appears that there are also divisions among the other professionals in the teams. *'The occupational therapists do this bit, SWs do this bit'*, *'there's a huge gap ... we sit and navel gaze ... lack of communication and co-ordination'*, and a cry out against this situation, *'let's not marginalise and sit in our boxes'*, *'too many teams work where you have lots of different professionals involved but they work in an isolated way'*.

Despite their earlier positive remarks about how they valued the role of MHNs, group members had experienced difficulties in their working relationships with them. One group member had had very positive experiences of working within a multiprofessional team, the same person who felt that the roles of SWs and MHNs were *'in many ways very similar'*. Even she, however, felt that this was exceptional, *'it's unusual here'*.

Changing the culture of teamworking and role boundaries was seen as necessary in order to improve the effectiveness of teamworking. This was, however, seen as no mean feat, *'to change the whole culture of a team will take years'*. However, *'it'll come eventually. It's got to do. It's the only way to get things done'*, *'there's a need to radicalise, but how do you change a culture?'*.

The way forward is unclear

The group members easily identified ways in which teamwork was failing but found it less easy to suggest ways of improving it and to give concrete ideas about what the future of mental health care might look like.

A project leader did have a radical vision of there being *'someone who can look holistically and access health and social services, voluntary agencies ... can network and make all those bridges without having to go to different individual people'*. Other group members questioned whether someone would be willing or able to do that. *'I don't know if you'd get such a superhuman person'* and saw the advantage of teamwork being the pooling of resources and knowledge, as no one could know *'everything out there'*.

It was believed that change and direction in mental health care was needed from the highest level. *'Culture change is only successful if you go to the very top first and make sure they are committed. If they're not committed you're going to be struggling.'* Were the professionals again abdicating responsibility for shaping their own destinies in relation to mental health care? Or were they looking for direction from their own professional leaders? Who are the leaders?

Education and training

MHN education, both past and present, was viewed by the group in a generally negative manner. *'When it changed to P2000 we noticed a lack of confidence and very basic interpersonal skills. They're not coming in with skills or the right attitudes in some cases. They seem to be missing something'*, *'there was a great hope to professionalise nursing, they'd be able to challenge and drive the profession forward'*. The DipHE had failed to meet their expectations.

Training in itself was seen as valuable, to some extent irrelevant of its content. *'That's really valuable, meeting with other people in your profession'*, *'it's valuable to take yourself out of the environment you're working in, see what others are doing, maybe learn a bit of theory and seeing if you can put it into practice'*.

'On the job' learning was valued by the OT, who felt that *'you have to have been working and have been qualified for a while and find your feet before you're able to do training'*. The SW described how she integrated her own ongoing learning and development into team meetings through the presentation of cases. *'Being able to present and make sense of the theory via the clients we were working with, that really helped me to learn more. It still does.'* This may have

potential for linking ongoing training into teamwork and combining the two, as in the use of educational vignettes (see Chapter 10).

5.1.5 Issues arising from Carers' and voluntary groups' focus group

View of mental health services

Group members had markedly different views from those of the members of the other groups. Their perspective was much more radical, with the assertion made that mental health services should be scrapped and started all over again based on the users' needs rather than service and professional needs. *'Some of the most valuable work has been ... [that which looked at] ... needs as they present, rather than saying, "Here's a nurse"', 'instead of looking at things from the top, look at things from where the users are', 'start from where the need is'.*

Much of mental health care has been transferred from hospital to community but, unfortunately, the methods for treating mental illness have also been transferred and were felt by the group to be inappropriate, *'you should be careful about allowing dependency to migrate from the hospital into the community, and just continuing the same kind of paternalistic care in the community'.*

'The medical model out of which a lot of our services grew is not appropriate' was a widely-held view within the group. Group members asserted that while services continued to be largely centred around the medical facet of mental illness, in fact *'only a small number of people need intensive medical model type care'. 'The help and support they need has not got much to do with the medical side of making them better.'*

View of the MHN

MHNs were perceived by the group in quite a negative way.

One group member felt that nurses had had quite a difficult time due to the transition of services into the community, *'the uncertainty, the insecurity, and problems of loss of identity that the staff are feeling with the big shift and dismantling of what has been a large institution'.*

There appeared to be confusion about what the nurse's role was, with members believing that everyone was confused about it.

> *'Everybody is confused about what the nurse in the community is supposed to do. The nurse is confused, the doctors are confused – hospital based and GPs – the users are most definitely confused. What is a nurse? What do nurses do?'*

Nurses were perceived as having a very broad role. Activities included, *'a listening ear, advising on benefits, delivering some kind of therapeutic service'.* The group felt that often nurses just visited periodically for a *'chat'*, and that this wasn't particularly helpful. *'Only came and had a chat, I can get that from a friend, it's a complete waste of resources', 'when a nurse says to a user, "I'll see you in a month's time", it isn't helpful ... popping in to see someone periodically is a waste of time and money'.*

Role of the MDT

The group were quite cynical about multidisciplinary teamworking, *'Professionals say the multidisciplinary team approach is marvellous, roles overlap and this makes for a dynamic services. There's no such thing at all'.* It was further felt that much of what any team member did could be done equally well by someone from another professional group, leaving the way open for the future development of the 'generic' mental health worker. *'Don't need to be a nurse to do those things. Could be any member of the team', 'if you followed some people around you would be hard pushed at the end of the day to tell which one they were'.*

Group members felt that the different professions allow their roles to contract, in order to make sure that they don't step on someone else's toes, and this led to there being gaps in service provision. *'They're all so careful not to overlap with somebody else. They draw back from their boundaries so gaps start to appear in-between what everyone's doing'*. This leads to *'a fragmented service'*. Because it is unclear exactly who is supposed to do what, there is a tendency to neglect the parts of their role which they do not like. *'[Nurses] will do less, because no one will pick them up if no one thinks it's their jobs ... just do what they enjoy'*.

In reality, often the only member of the MDT that clients saw was the MHN. *'For many users, the nurse is the only person that they actually see, that they come into contact with, who is there to help them'*, *'most people don't have any of these services, they have a nurse'*.

Again, GPs were viewed in a negative manner, *'GPs just don't want to know. You put on training sessions, they will not come'*, *'there is never any [GP] representation ... they miss opportunities'*, *'[GPs] have a gross ignorance of mental health problems ... there's no excuse, they need a boot up the backside'*. We had difficulty recruiting GPs for this study, which may reinforce the feeling expressed by this respondent.

Users groups as a way forward

The members of the group considered that users had a great contribution to make towards the provision of their own services. They were *'the experts in their own fields'*. A project was described where users had been involved in providing the services they were using, *'it has been done and been incredibly successful. They're good at designing services'*.

5.1.6 Summary of focus group findings

While several issues and themes were raised, it was evident that much work still needed to be done to excavate important parts from the analysis. For example, we were beginning to uncover tensions, contradictions and influences which determined professional performance of the MHN within multiprofessional teams.

5.2 Initial survey results

The number of surveys used in each of the eight sites were:

- 24 Education
- 40 Service (four different care settings, 10 per setting)
- 36 Users and carers.

Education participants included mental health lecturers (pre- and post-registration) and other lecturers involved in teaching mental health students, lecturer-practitioners, educational consortium members, DipHE mental health students Years 1, 2 and 3, degree students (mental health) and post-registration mental health students (involved in a range of programmes). In each of the educational institutions, eight or nine surveys were administered to lecturers and the remaining surveys were split equally between pre- and post-registration students.

Service participants included MHNs, CMHNs, service managers, locality managers, multiprofessional team members (e.g. OTs, SWs, art therapists) and support workers.

The Users and carers sample was primarily composed of current users, but also included survivors, carers and representatives from voluntary groups, self-help groups and special interest groups.

5.2.1 Response rate

Taking an average of the response rates achieved over the eight regions, we achieved the following total response rates:

- Education 48%
- Service 43%
- Users and carers 21%

5.2.2 Findings

The survey responses were analysed using the effectiveness and congruency indicators. These data have provided us with a general picture of the educational preparation for mental health nursing and the contribution of the nurses within the multiprofessional multi-agency team.

Frequencies were computed for all questions on the returned surveys. The actual surveys and frequency observations are available from the authors, and are referred to in Chapters 6-9.

Particular areas of interest identified by frequencies were picked up in the case studies. For example; 82% of the User focus group agreed with Question 11: *'I did not realise there was a team providing care'*, and yet 57% stated that they were aware of each team member's role (Question 13) and 68% agreed that the team providing care was very good (Question 12). The Service focus group claimed to have effective multiprofessional teams in response to particular questions, but offered contradictions in their open responses where they identified many shortcomings.

We found a correlation within and between group findings, and in addition we found no significant regional variations. Thus, we concluded that each group was homogeneous. This result affected how we collected our data during the case studies.

Specialisms tended to disagree with CPNs that MHNs had poor practical training. Males tended to disagree with females that pre-registration education enabled work in both hospital and community and also that MHN education and training was relevant for practice. Education and Services groups disagreed between the ideal and real role of the MHN. Users and carers rated various tasks differently from service providers. Users and carers felt that the more informal and personal aspects of care (e.g. listening) were more important whereas service professionals rated skills (e.g. assessment) highly. These were useful areas to explore in the case studies.

FINDINGS AND ANALYSIS: ASPECT 4 – THEMES FROM THE CASE STUDIES AND LINKS TO THE SURVEYS – SERVICE USERS

6.1 Introduction

This chapter and the three that follow it report the findings of the case studies. Data are drawn from a wide number of different encounters with respondents in educational and practice environments. We used direct observation and interviews of the various professionals at work and with service users as they were encountered at different points within the statutory and voluntary service provisions.

We pursued common areas of enquiry and also developed more specific areas for closer scrutiny. Thus, some of us worked more closely with practitioners, educators, service users, service commissioners and groups of individuals located in different teams and practice settings. Many of our insights into how practitioners work together have involved the deconstruction of multiprofessional relationships, and particularly a critical scrutiny of what may have been occurring *'... beneath the surface of social interaction'* (Mohr, 1995: 86). We found an analogy in social anthropology that was useful in our thinking around multiprofessional relationships – how practitioners see each other and work together as part of the multiprofessional team. Teamwork dynamics can be likened to a *'Pentimento'*, which relates to the layers of significance and meaning overlapping, in ways similar to: *'those old paintings in which one image has been painted over another, but the overlying image is so thin that the one under it still shows through'* (Arney and Bergen, 1984: 8). Considering how professionals relate to one another, on different levels of discourse, meant attempting to understand layers of meaning which were sometimes only scarcely apparent. The implications for our fieldwork involved us in having to be cognisant of practitioner 'baggage', interprofessional relations, group pressure and individual influence.

Early analysis of these fieldwork data was used in the development of a report-and-respond (R&R) survey, which was administered to educators, service providers and users drawn from within the case study sites. Findings from the R&R survey and, where appropriate, findings from the initial survey, are integrated into the text. The aim of the survey was to gain a general overview from individuals in relation to some responses we were collecting about mental health nursing, multiprofessional teams and the education and training for such teamwork.

This chapter reports on some of the issues that emerged from the service users' experience of mental health care in general and mental health teams in particular. These experiences are explored and built upon in Chapter 7, where the experiences of users, service providers and educationalists are noted in relation to their understanding of the underpinning policy for current mental health care and how this is realised in contemporary practice. Chapter 8 provides a much closer examination of these practice issues, in particular focusing on the MHN and mental health nursing. Finally, Chapter 9 completes the cycle as the experiences of students, educationalists and practitioners, as they were involved in the education and continuous development of MHNs and their preparation for teaching, are explored.

6.2 Service users

6.2.1 Sampling difficulties

At the initial data collection stage it proved difficult for the team to identify mental health users who might be interested and willing to participate in the study. The eventual sample was made up of a collection of individuals who had been in contact with the various services for a number of years. Some of these individuals had experienced care and help in ways

that were seen to be disabling rather than enabling. However, this experience highlighted a number of important and somewhat paradoxical issues for consideration. These issues included seeing users as:

- being part of hidden populations, but where there were highly visible individuals
- a group of people who were sometimes disordered in their perception, yet where there was often a clarity of personal experience
- being reluctant or unwilling to make a personal investment in mental health research because of the unknown outcomes
- being part of a range of identifiable and accessible user groups but who remained largely inaccessible as individuals.

As the project progressed, a second problem emerged – achieving informed consent from potential respondents. Users were approached, usually with the service organisation representative acting as a gatekeeper. Several ethical issues were raised, which included the need to:

- err on the side of caution when considering service users' understanding the nature of their involvement and the commitment needed
- avoid service providers heavily influencing decisions made on the part of the individual user as to whether to participate in the study
- gauge how much help we should give to individual users in physically completing the questionnaires and the impact this might have on the validity and reliability of data collected.

We also ensured service users were told that they could withdraw their consent at any time, and a number of individuals exercised this right during the study.

In addition, many users (particularly, but not exclusively, those closely identified with user groups) expressed concern over becoming involved in yet another piece of research without knowing whether it would result in any change for them:

> *'We have been involved in many research projects, but although people say things will change they never do, most of the time we don't even get to see the results of the research ... when there is nothing in it for us, you can hardly be surprised that nobody wants to help.'* (Service user)

However, despite these difficulties, a significant sample was achieved across the eight regions and in one region in particular. This sample included users who were at various stages of their illness and/or recovery, although the sample was predominantly made up of those individuals with a SEMI problem. The sample also represented users who were located within different care environments. Service users were seen in a range of non-service settings which included user support groups and user organisation offices.

Our dilemmas in trying to achieve a representative sample of service users in a variety of settings reflected the problems many mental health teams have in working towards increasing user involvement. At one level, there was an under-representation of groups that could be included, such as respondents from ethnic backgrounds. We believe that the final sample appropriately reflects those users currently the subject of mental health policy, but our difficulties illustrate the shift in recent times of the criteria for user involvement from 'Why involve users?' to 'Which users do we involve?'

> *'I think users should be involved in many aspects of the services provided, but a balance has to be struck between involvement and decision making. Many individual users do not have the information, for example, to fully participate in service purchasing decisions. Some user groups are only*

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interested in particular mental health problems ... But we do audit user satisfaction surveys, we have a patients' council on our acute admission wards, and some of the long-term residential services have their own user management committees.' (MH Service Commissioner, health authority)

Despite the problems of accessing and finding users, once contact had been established and consent obtained, many of the users were very willing to share their thoughts and experiences with us. In some instances, contact with particular individuals or groups continued over sustained periods of time. Below we offer some significant themes that we feel represent the users' experience of mental health care.

6.2.2 Developing identities – 'time tells you'

Time was a commodity that was used by many service users in recounting their experiences of mental health services and mental illness. Often those individuals with a SEMI had too much time, through a lack of employment or any purposive activity being available. Often they were dislocated from families and lived alone. Many of the service users gauged their worth by the amount of time a particular practitioner spent with them. Ward staff came in for particularly harsh criticism:

'You're lucky if someone speaks to you after the first day [as an inpatient], I think I've only ever seen the sister sat in the office.' (Service user)

'Dr B. sees you for about five minutes max and then you're out, no by-your-leave or anything. They just sit there writing down notes and hardly notice if you're upset or the like ... I like the students best. At least they seem to have time to sit and talk to you.' (Service user)

'It's really frustrating sometimes, you go onto the ward and can't find a member of staff anywhere. No one knows who their key worker is and I find myself wanting to scream. What do the nurses do all day?' (Service user)

We explored this theme of service users defining their worth in more detail, linking it with how they developed their identity.

Our findings confirmed previous research that often the service users have clear ideas over who they were and who they were not. Although terms such as *'mental patient'* or being *'mentally ill'* were sometimes expressed, most often individuals saw themselves as someone who suffered *'mental distress'* or someone who was a *'mental health survivor'*. The more traditional (medical) terms were largely rejected by the respondents in favour of the individual's experience being viewed not as a collection of symptoms, but as a reaction at any particular point in time or within a particular context. Most respondents could phrase their problem in the correct medical jargon, and some who were connected with more *'conservative'* groups (such as national MIND or SANE) had no problem in describing themselves as *'schizophrenic'* or *'depressive'*, which matches well with Emerick's findings (1991). The user can attempt to take control in the form of becoming an *'articulate patient'* and in so doing, reconstruct an identity for themselves around their illness.

'I am schizophrenic, what more can I say? I have a wife, a house, a job, children. I know what I am, I know what works for me and so does my family. If I had epilepsy or diabetes I would have to follow the treatment plan to stay healthy, so it's no different for schizophrenia. I really don't understand people who try and call it something else like 'severe and enduring' yeah? Changing the name doesn't change what it is ...'
(Service user)

6.2.3 Relationships

Such experiences suggest the existence of a possible relationship between the givers of care and the receivers of care that is informed and constructed on both *'real'* and *'potential'* identities of the participants to that relationship. In the users' experience, this relationship was seen as being something that changed over time, dependent upon the course of the mental health problem and who was involved. Although generally the psychiatrist was seen as the most inaccessible member of the team, they were not the least useful – this was the GP. Often these relationships changed with both time and place. Many of the users only felt able to discuss the experiences of the care they had received in hospital settings once they had moved out of this situation:

> *'In the hospital they [nurses] use their position as if they have got power over you ... No, power is the wrong word, it as if they are in authority ... it's their game and you have to play by their rules ... When they come to my house it's different, they have to be different, it's my house and my rules apply!'* (Service user)

We also found differences in perceptions as to how relationships were experienced between the nurses and users. In conversations with MHNs working in both the hospital and community services, they often described their role in the relationship in terms of *'enablement'*, *'empowerment'* and *'intervention'*. However, in the conversations with the users, they often only experienced and described *'intervention'*, usually in the form of treatment, confinement or some other direct action. Morrall (1998) stated that MHNs are, by their nature, social controllers, even when they have the title of CPN or CMHN.

> *'I am not hung up on titles because I think they are meaningless and they just provide a security. When I have tried to work out what each professional does it boils down to the SW doing benefits and the MHN doing injections. Beyond that I do not know what the differences are. If you ask the clients who was the best person you ever had to give you care they will not tell you the SW or the nurse, they will give you the person's name – Bill or Sally.'* (University lecturer and CPN)

Even where the users' experience appeared to include activities of everyday life, such as in the work of the OT, where activities are aimed at increasing independence, there was a paradoxical increase in relationship dependency levels, as these everyday activities are given a professional and organisational significance. This perhaps returns to the theme of disabling rather than enabling the client:

> *'It's great here, we get to do all our own shopping and cooking, we all have to take turns at cleaning ... they are preparing us to cope with life outside ... you know when we get discharged ... I know most of this stuff, but I guess it's better than just sitting around all day.'* (Service user)

We believe that these reported relationship experiences illustrate a continuing dominance of the mental health professional's discourse in determining the basis of the user-professional relationship at an individual level and possibly, at the collective level. Perhaps the significance comes in the empowerment of users. While all the services used as case study sites made some attempt to involve users in various ways, there were differences in how they worked towards empowering individuals.

> *'If you ask the nurses something about your tablets and they don't know, you are fobbed off ... you are told to ask the doctor ... but they only deal in what they can prescribe and that doesn't include such things as St John's Wort or essential oils!'* (Service user)

The initial survey data suggested that gaining access to help that proved *'useful'* to the user was not always dependent upon those most often in contact. Users tended to favour greater use of informal networks rather than professional encounters, although this was extended into the professional arena:

> *'I've had a lot more support from the support workers than from the CPN or the nurses in hospital.'* (Service user)

Both groups agreed that more mental health care could be provided by unqualified staff such as support workers and HCAs, perhaps raising the question of the future role of the qualified MHN. (This aspect is pursued further in Chapter 7.) It will be crucial for MHNs to consider how the organisation of the therapeutic environment within which they work (hospital and community) can create barriers between them and the service user whereby participation and empowerment become mental health care myths.

6.2.4 Participation myths

Mental health care could be viewed as a dynamic and unpredictable ecosystem. This ecological view acknowledges that service users have much to offer from their personal experience of mental illness. They can contribute to the way in which mental health needs can be articulated, and how these needs can best be met, although the professional health care worker might not always share these perceptions. However, the individual user is not just a consumer of health care, but is also a citizen in a society that has often discriminated against them. In fact, MHUGs and organisations, it can be argued, have grown so that these wider discriminations are addressed. Most formal user groups, however, constantly balanced decisions about how their scarce resources should be allocated between the needs of the individual and the needs of the wider community:

> *'We run an open house policy here. Individuals can come and ask for advice and help, and in most cases we will respond and work with them, but most of our effort has to be on addressing the wider issues of fair access to housing, improving employment opportunities, researching service outcomes and interventions, and lobbying the Health Authority for greater inclusion in their planning processes.'* (Manager, Regional user group)

Individuals reported a similar balancing act between ensuring their own needs were met and the needs of the wider mental health service user community:

> *'It shows what society thinks of mentally ill people. I don't ever recall seeing a general ward anything as bad as the mental wards. They should run these wards in the same way as they do for people who have diabetes or a heart problem ... there should be no difference ... some of the conditions on the wards were disgusting.'* (Service user)

> *'I remember when I first went to a meeting, and my eyes were opened! The speaker was from some group or other but was really passionate, telling us to get off our arses and make a difference to our lives. I started off helping with the news-sheet and gradually got more vocal. It's been really helpful to me. I have bags more energy now and lots of confidence. I didn't get that from haloperidol!'* (Service user)

We found a limited number of service users who were involved in such things as planning or evaluation of services. In one area they were involved in interviewing a member of staff for a job. However, the more usual experiences was one of tokenistic involvement:

> *'They [managers] talk about wanting us to become involved, but then expect us to do it our own time, for free, and what do we get out of it? Ahhh, the pleasure of knowing we contributed our bit. No, it isn't equitable, they want to use us as consultants but then don't want to pay for it. If it was you or anyone else they would pay you.'* (Service user)

'It's a bit cheeky really, I get a 'phone call from the trust asking me to bring along "a user", just like that. I turn 'round and say that if they want a user representative I can ask if anyone is interested, but that's it. They just want someone so they can tick the box and say they have a representative, as long as they don't ask any questions. It gets me so mad!'
(Voluntary services worker and Service user)

Data from the initial survey reinforces the view that a substantial percentage of users felt they should be involved in various aspects of providing services (planning 88%, helping to provide 77%, education 74%). This was also confirmed strongly in the R&R results, with 89% feeling that users' involvement with MHN education and training for teamworking was currently too limited. This was felt to be because educators (85%) and the service side (81%) did not encourage user involvement. The R&R results also confirmed that the users (97%), carers (98%) and voluntary agencies (96%) needed to be heard more, indicating an appreciation of this shortfall across boundaries. Some users were involved on a formal basis in education, but this seemed almost exclusively to have been through particularly committed and interested educators rather than a curriculum fixture. A common problem was one of payment again, the users almost being seen as having to be grateful to contribute. A number of users and educators found the sessions difficult, and in some cases harrowing, staff finding themselves in confrontational situations in the classroom, and in some instances users feeling threatened by antagonistic staff or students.

'It did become a real problem, some of the service users had to leave because the students were so hostile. Now I make sure that I am in the room with them, and so far it seems to work well. Now we have a supporting course to allow user and voluntary agency reps to gain the skills in presentation in the classroom. One real problem is that a session can become someone's rant for or against psychiatry.' (Lecturer)

Carlile (1996) is an advocate of shared sessions with users and lecturers, recognising the difficulties in sessions being run by unprepared or unsupported speakers. Many service users felt that they were being used 'on the cheap' or for 'lip service' for such things as teaching or service planning. Rarely did they feel they were listened to or even, in some cases, treated like knowledgeable thinking adults. Indeed, the service user on our Steering Group echoed these sentiments from his interactions, albeit not with all group members.

A large percentage of respondents (57%) felt they were not actively involved in their care plan. Those respondents who did feel they had a say, praise staff that were seen as friends, mentors and colleagues. Examples of true collaborative care between a multiprofessional team and a voluntary agency were few and far between. The R&R results indicate that voluntary agencies were not seen as part of the MDT (72%). Some voluntary agency representatives felt that they were an 'add-on' or a convenient dustbin for difficult clients, and that they were seen by the statutory service 'professionals' as bumbling amateurs.

'I know my clients inside and out. If Bill or Ada tells me they aren't right I believe them. Try getting a CPN or an SW to come and see them though, you can almost hear them sigh – in fact one did once, cheeky sod. They make you feel stupid and insignificant. Now I tell them, "Bill is having auditory hallucinations of a persecutory nature, which means he wants to hurt himself. He has increased his dose of thioridazine but it hasn't helped and now he is becoming anxious because he's starting to exhibit tardive dyskinesia." They don't half get annoyed when you do that 'cos it sounds as though I know more than them. It gets 'em moving though.'
(Voluntary agency representative)

It is clear that unproblematic collaboration with users is largely tokenistic, or at worst a myth of current educational and practice policy rhetoric. We found that other areas of service

user involvement provided similar experiences and accounts, for example, how services users have or haven't developed advocacy services.

6.2.5 Advocacy and the user

Advocacy has been a key issue in the field of mental health (McFadyen, 1997). However, the development of user advocacy schemes has been patchy and rhetorical (The Mental Health Task Force User Group, 1994). We offer one example that serves to illustrate the difficulties in making progress in this area. In this example, professional practice, underpinned by a dominant medical culture transmitted by the social organisation, results in an almost insurmountable imbalance in power between users, managers and professionals.

The example involves the development of a patient advocate scheme, which had been introduced onto the acute admissions wards of a large mental health service. The scheme involved (former) users of the service acting as advocates for current inpatients. Recruitment of advocates relied upon trawling user groups in the area for volunteers. Training was offered to individuals and this was funded and provided by a larger independent user association. The scheme had been in operation for 12 months, and involved 18 advocates. The service manager responsible for inpatient services perceived the initiative as being *'something long overdue'* and *'vital if we are really serious about being transparent in terms of what we do'*. He had been largely instrumental in working with a range of different formal user groups in the development of the scheme. However, others involved or affected by the scheme were less enthusiastic. The advocates described their involvement as being *'frustrating and difficult'*. They felt they were not *'taken seriously by ward staff'*, and had never *'spoken to a doctor [psychiatrist] in carrying out their work'*.

Although they had the support of the service manager, the advocates felt alienated by ward staff, and this feeling was heightened by the difference in perception of shared roles between the advocates and the nursing staff. The advocates were more concerned with outcome: *'we sort out what each patient wants to happen, that's the most important part of our job'*, whereas the nurses appeared more concerned with process: *'I involve every patient in drawing up their care plans, and explain what the treatment involves'*. The nurses viewed the scheme as useful but *'limited'*. There was an undercurrent of their nursing role being usurped in their response: *'we are trained to care and protect patients including vulnerable individuals'*.

The alienation of the advocates appeared to result from the nurses' perceptions of the nurse's place in the hierarchy of power in the organisation being threatened by the work and intent of the advocates. Often the nurse's role within the team involved conveying to service users decisions which are often collaborative (made by the team). Those decisions may be unpalatable to users, yet there is a sense that the decision is beyond the responsibility of the individual nurse and is a team decision. This illustrates yet another difficulty in promoting empowering care approaches, where MHNs find they have dual allegiances – to the values of the team, and to the need to advocate for clients.

Likewise, anomie appeared almost inevitable (see Chapter 2), as the prevailing culture of the professional (nursing) discourse with its concentration on process clashed with and successfully rejected the cultural norms presented by the advocates' concentration on outcomes.

We suggest that while the advocates, in continuing to accept their limited role, could be said to have achieved an accommodation in this position, resistance to this state of being was channelled and organised through the parent user groups. This took the form of publishing (albeit in the grey publishing economy of local user groups) accounts of their work, self-help guides and user satisfaction surveys. The pervasive power of both professional practice and organisation appear to work against the development of new professional and organisational cultural norms. We would argue that given that users need advocacy and support in order to increase their self-confidence in dealing with professionals, this experience at individual level does not take user involvement above the passive and ineffective.

We also found some evidence of the professional-as-advocate approach. We argue that overcoming the problems of being *'part'* of the professional organisation and the conflict of interests in which this can result, limits such approaches. In the context of multiprofessional teamworking, these limitations can give rise to role conflict:

> *'The SW has to deal with all the legal side of treatments, and their role includes sorting out patient rights, benefits, housing and the like ... we don't get involved in this other than at the CPA meetings ... Our role includes trying to build the patients' self-confidence up so they can speak for themselves at the case meetings ... but there can be difficulties, especially if a patient makes a complaint against you.'* (Ward manager)

It has been argued that the MHN's role as advocate cannot be simply taken as read, and further that the way the nurse is educated in preparation for this role needs attention (Woodrow, 1997). It is interesting that in the survey the MHN comes second to the counsellor in both considering the patients' point of view (counsellor 74%, MHN 73%) and in who speaks up for the patient (counsellor 70%, MHN 62%). The research then only partially supports the view of the MHN as an advocate. Such dilemmas can be seen already in the relationship between carers and users, whose views on a particular situation or illness might differ:

> *'My dad wanted me to come into hospital and had contacted the CPN. I wanted to stay at home and get some help there ... My dad won and I was sectioned and taken into hospital ... It was a dreadful time and I thought the nurses were more concerned about pleasing my dad than listening to me ... In those types of situation you can never win.'* (Service user)

6.2.6 Boundaries and barriers to user involvement

We would argue that service users' participation within the mental health field could be possible at a range of different levels. However, there appear to be very few examples of national initiatives being (a) developed and (b) successfully including users in the planning of services (Barker et al., 1999; James, 2000). Van Hoorn (1992) points to Amsterdam as a (failed) case in point. The professional discourse, which may lead to anomie for the user in the form of accommodation and/or resistance, is very powerful. For example, interpersonal skills on the part of unqualified staff (including student nurses) were highly valued by the users, but were said to 'disappear' as the student qualified, or the visibility of nurses (particularly on inpatient wards), and the enculturation of individuals into the norms of both professional and organisational practice.

We agree with the assertion that CPNs in particular have a unique role to play in relation to involving users in service planning and evaluation (Martin, 1984). With the emergence of PCGs and PCTs, their wide-ranging membership should ensure that the needs of mental health service users requiring specialist and non-specialist services are more effectively met. Some respondents described the role of the CPN as being like a 'go-between' who is able to move across organisational and professional boundaries. The user could share this position. Users are often involved with a wide range of different agencies, and although this might occur at different points on their illness trajectory, this experience is likely to be rich in terms of effectiveness and congruency. Given the paucity of information available to the service commissioner of the purchasing, development and delivery of mental health care, we suggest that the experience of the users would appear to be an important factor in such decision-making processes. Simpson (1999) believes the involvement of users in identifying and realising the training needs of MHNs working in community settings can hopefully shift the emphasis of service provision from being service led to needs led. If this is possible at individual level, it should be possible at organisational and national levels of mental health care. However, Simpson notes that in order to effectively involve users, changes to MHN education at pre- and post-registration levels need to be addressed. We found that although many of the respondents in

the user survey felt they could be involved in MHN training, many comments illustrated that *it was difficult to say what this involvement might be*. However, we believe that as the likelihood grows of more training and education being provided in the workplace and therefore achieving a greater contextual legitimacy, the greater involvement of users and carers is something educational and service providers will need to address.

However, despite recent exhortations contained in current policy directives towards greater collaboration and partnership, and the recently published framework for mental health services in the UK, it appears that the risk remains of anomie and social fracture continuing for the mental health user. Users also suggested that organisational structures may inhibit progress as much as social and cultural factors. The users' experiences and the issues raised in analysis are pursued further in the next chapter, which explores the policy perspectives and experiences of our respondents.

UK mental health policy is represented in directives from central government and the professionals' interpretations of these policies and the transformation of these policies by practitioners, educationalists and managers into practice. At national level, the objective of mental health policy is to provide a clearer context for the organisation of professional practice at the individual level. However, a number of pernicious factors (including disciplinary ethnocentricism, professional protectionism, role rigidity, dysfunctional work environments, overwhelming work demands and lack of resources, Botelho, 2000) have contributed to the paradoxical situation where policy guidance has resulted in less clarity and increased turbulence, or messiness – a policy swamp. This argument is given some salience by the experience of many of our respondents, for example, 84% of the R&R survey respondents indicated that the role of the MHN was seen as increasingly problematic. As the case study visits were undertaken, we sought to examine the impact of policy on our respondents' practice and felt experience.

7.1 Laying foundations

The current policy 'ideal' promises much in terms of new resources and political resolve. The policy guidance relies upon repeated exhortations that collaboration, partnerships and integration will replace competition and independence and, thus, lead to integrated services, interprofessional working and interdependent service providers and users. However, this policy hegemony is unlikely to be able to achieve these objectives as the prescription (in the form of national standards and service models) runs counter to the concept of locally-derived health needs assessments. Currently, political objectives are translated into NSFs, new organisational structures and operating environments (trusts, PCGs and health authorities) and national standards and league tables. These translations have resulted in paradoxes being created, underpinned by largely mechanistic, linear, economic and ethnocentric professional discourses. For example, it is difficult to achieve a balance between autonomy and accountability and continuing freedom to practise professional health care in a performance economy constructed around evidence-based approaches and consumer satisfaction. Further, independent professional practitioners are being made more dependent upon the state (in order to practise health care) through a policy framework that espouses interdependency.

> *'The biggest change we have had in terms of resources came from contracting. The introduction of the market system was better for us … Before then any savings we made were taken back by the health authority to pay for services at the City Hospital. It happened every year and we couldn't stop it. When contracting came along and we had specific service specifications, we actually gained more money because the health authority wanted to change services and increase child mental health services. We now have a child and adolescent service that we wouldn't have had under the old system.'* (Service manager)

This respondent's experience is not atypical, and illustrates the worst aspects of managing a system relying on both planned (based upon co-operation or co-ordination) and market (based upon competition) approaches. Building on the work of Sahlins (1988), Waldrop (1994), Capra (1996), and McBurney (1999), we developed a framework built around co-evolution for how respondents were situated in the various complex systems of health and social care. For example, there has been a strategic drift in the operational focus of many MHNs. In ecological terms this is like one part of the ecosystem finding a niche for itself which it will inhabit until the pressures of the wider system force it to adapt and behave in a different way. In such a system, unity and coherence is only possible through diversity. In organisational terms this presented us with a further paradox: Given the paradoxes and contradictions apparent in

policy arena, is it possible to train an individual (in this case the MHN) to be able to effectively respond to such diversity?

Current mental health services are to be restructured into specialist mental health trusts/services where an effective interface between 'specialist' mental health services and primary care services is required. However, we argue that despite the governmental 'modernisation' programme, aimed at providing a mechanism to 'smooth' this turbulence, our data highlight that moving from the possible to the probable through the intentional involvement of others remains highly problematic, despite the rhetoric of integrative policies.

7.2 Need for change agents

Norman et al. (1996) and Miller et al. (1999) examine the educational preparation and practice of nurses in multiprofessional settings. They raise several issues, including how to develop more effective working practices to achieve focused multi-agency working, particularly in the post-market environment of the new NHS. PCGs and PCTs will develop locally sensitive health care services through commissioning strategies based upon multi-agency integrated Health Improvement Programmes (HImPs). However, before these organisations can be truly effective, a great deal of resources need to be expended in establishing a shared sense of identity, values and trust. Our data illustrated the difficulties some individuals had in trying to marry the external demands of policy initiatives with the internal organisational capabilities, resources and ideology:

> *'One of the problems we constantly face is trying to ensure that we plan long term and start to bring about changes and improvements whilst still offering the existing level of services. In mental health, where relationships and partnerships are so important, changing working practices and cultures takes a long time. The timeframe of some of our service development plans are determined more by the Centre [The NHS Executive] than by any real reflection of our assessment of the local needs, and this puts great pressure on everyone. I think we need to find ways of involving more practitioners and users in our decision-making, and then we perhaps would get better ownership of the change process. But it's difficult to achieve this when most of our providers are already struggling to keep their heads above water as it is. Trying to manage existing services when you have staff shortages, such as psychiatrists, is proving to be very difficult. It does present us with some opportunities for change, like developing nurse-led assessment services, but this is really at the margins.'*
> (Health authority MH services commissioner)

There is an acknowledgement here of the systemic nature of trying to achieve change within and across health care organisations. The external perspective is concerned with planning, thinking and acting strategically, while the internal is concerned with the everyday reality of practice. Thus external demands for achieving greater integration require operational support and empowerment if future relationships are to change. In such situations individuals are required to lead as change agents. In one of our sites we found a good example of a charismatic service manager who appeared to be beginning to operate in this mode:

> *'I brought together a project team made up of voluntary sector organisations, like MIND, National Schizophrenia Fellowship, The Peters Housing Association, SWs, and nurses to pilot a Link Worker Scheme for people who are in contact with the service or who are referred to the service. We wanted to try and ensure that everybody involved in mental health, whatever their background or purpose, had a better understanding of what was available when an individual patient or client presented themselves. We identified a group of nurses to act as ward-based link workers in the first instance and*

they were trained and get supervision from these different organisations. It's been running now for six months and although there have been problems, these have come from my organisation … the trust, who are still wary about what we are doing. For example they are worried about who takes responsibility for the patient, confidentiality, etc.' (Service manager)

Likewise, one respondent in a college of nursing adopted a similar approach to his relationship with students, although this wasn't extended to his relationship with service staff:

'My role is to be provocative, challenging, even awkward. It's no good teaching them what the book says, you've got to expose them to the real world. There are no perfect answers, things are a mess, we are all a mess if we are honest, that's the reality and that's what I try and get them to see … They have to develop skills and confidence to deal with the mess …'
(Branch lecturer, Mental health)

7.3 Maintaining the *status quo*

We found little evidence of this approach at a more strategic level.

'We were unable to make much progress with our Community Care Plan with the LA [Local Authority Social Services Department] and I don't think the new Health Improvement Programme will be any better … our agendas are different, and our organisational cultures are too far apart. They always have to keep one eye on what the local councillors want, they are more political than we are.' (Health authority director of service development)

'Although mental health is one of the big five targets for us to achieve, the issues involved haven't really been addressed very well in this Health Authority. Since we lost a load of staff recently, the role of commissioning and liaison has fallen to me, and it's an add-on to everything else I do. We are having lots of meetings with trusts and the Social Services, but I am not sure which direction we should be moving in … Everyone is waiting for the National Service Framework to be published, and until then everything [service agreements] is being blocked back to last year's providers. I am not sure what GPs will do this year; many of them employed their own counsellors. And it remains to be seen if they will have the same resources to continue doing so this year.' (Health authority director of commissioning – interviewed prior to the publication of the NSF)

At the individual level of service provision, there was evidence of a range of 'defensive practices', which were employed in order to maintain the *status quo*:

'We have limited resources and we have a responsibility to use these resources in the public's best interest. We would like to expand our services and to look at new ways of providing treatments and care, but at present this is not possible. There are economic issues of scale involved here and sometimes this means we can't always do what we would like to do …'
(Service manager)

'There is a constant problem of making sure we have the right number of beds available, with the right level of staff, numbers, experience, etc. If we don't do this we run the risk of something happening and our service being splashed all over the paper … but we still take risks, you know like we always use our beds for more than one patient and hope that nothing happens and they all need to be here at once!' (Ward manager)

'These services are supposed to be one service, with consultants having both a hospital and a community team. It seems to me that psychiatrists still largely dominate the service and they are more concerned with the number of beds they have than any real commitment to developing integrated service. On my visits here [CMHC] I tend to see the CPNs more often than Dr S. [psychiatrist]. I've never been invited to a CPA meeting at the hospital and haven't been around the wards for years.'
(Visiting GP)

Given these experiences, it is difficult to see how a shift away from commissioning decisions that are largely provider driven, to a more needs-led approach, will be achieved. There is a further paradox here. The policy change away from formal contracts for services, which were complex and unwieldy, to longer-term relationships built around service agreements should increase the benefits to be gained from more enduring and informal relationships. Yet it can be argued that pre-existing custom will be used to maintain a *status quo* of provider-driven independent services. Such customs can be very powerful and include historical referral patterns, individual rather than team interventions and decision-making processes which are often located within personal and professional networks.

'We have a problem with some of our junior doctors. If they work on Dr P.'s team they will try and admit nearly everyone they see in outpatients just in case they [the patient] does something and they have to answer to Dr P. ... It causes us all kinds of problems as many of these patients come in, are here for 24 hours and we have to get them discharged again because they aren't acutely ill ... If I'm here I can sometimes stop this, but if it's one of my junior staff they've got no chance ... even though many of my nurses are more experienced than they are!' (Ward manager, acute admission ward)

In addition, we found professionals working within different service provisions did so in a way that established a delineation of practice which, again, appeared to maintain the *status quo*. For example, psychiatrists and SWs often appeared to deal with those people eligible for the CPA, and psychologists and counsellors often worked with those individuals with a less severe problem. CMHNs were often seen to liaise with both these groups (even where it was a secondary service provider that employed them). However, many of these CMHNs continued to deal with large numbers of patients who did not present with a SEMI problem. Some respondents clearly saw this 'spanning' role as being negative, due in part perhaps to the competing demands made of them by opposite ends of the mental distress continuum. However, other team members described this 'spanning' role as being a positive factor in relation to developing multi-agency approaches, particularly in moving away from a medically dominated view of mental health care:

'My first experience was going to the weekly referral meeting and sitting there and my jaw just hit the table ... What you had was a series of referrals sent in by the GP in the main ... The amazing thing for me was the amount of knowledge the CPNs had, not just about the individual patient, but the fact they knew the granny, the social environment ... they had a mass of social knowledge, they were a walking database and they were willing to share. That sharing created a wider picture of what the patients needed given what they presented with.' (Counsellor)

This respondent appeared to be alluding to an example of the more ecological approach to mental health care that is paradoxically espoused in current policy. The reported CPN experience was constructed around the ability to build and sustain relationships beyond the particular patient, used informal methods of working, was situated within wider social and professional networks and was presented in an interdisciplinary way. Being aware of and harnessing these wider networks would appear to be important.

'We all have problems, I don't think it's right to say that some are more important than others. It's like what's important to you at that moment … when I have been in hospital I have thought that some of the others [patients] were in a much worse state than me and have wondered what I was doing there using up a bed, but at other times, something has happened and I felt really low and alone. I could have done with someone, anyone to talk to, but it's not bad enough to ring the doctor, you can't come here [CMHC] and you have to get on with things … I think they only take any notice if they think you might do something to yourself … you know, try and commit suicide or something.' (Service user)

7.4 Further barriers to progress

The policy focus on SEMI reinforces a professional rather than a lay view of mental health, and with it a polarisation of service provision that is largely rhetorical and irrelevant when judged by the reality of the services users' experience. Further, actual user involvement remains largely unfulfilled. For some, their experience had left a long-lasting and largely negative perception of oppression and pain. These emotions were often openly expressed and raised issues over future service user involvement, although such expressed emotions were often directed at other social institutions and not necessarily at individual practitioners:

'Why should I help you, we keep doing these things but it makes no bloody difference … You can go back to Manchester but I'll still be left here with the same old problems. I can't work … you try living on benefits … would you want to come here of an evening? All the research in the world won't make any difference. There is not enough money being spent. This lot [New Labour] are just as bad as the other lot. They are changing the rules now for incapacity benefits. I am OK, but if you get depressed now and can't work, you have to be assessed and you only get incapacity benefit if you get so many points. Most people with mental problems are not going to get enough points … I think it's all wrong – you can't help being ill can you?' (Service user)

Other complaints, included the 'invisibility' of nurses who were often thought to be in the office, heavy-handed approaches by some staff to difficult situations, use of language which was difficult to understand, and a lack of consultation over care plans. Raising complaints was seen as being impossible and some users felt that making a complaint would lead to a worse situation.

'They talk to you about how you are feeling and try and get you to do things. Most of the time you are treated like an adult but if you don't want to do something or things are not working out alright, like you are not getting what you want, you get treated like a child, you know, you don't have any say in anything. I was a teacher before I became ill and although I have been depressed I haven't lost my marbles!' (Service user)

At the national level of policy development similar problems are evident. For example, sensational newspaper stories about occasional violence committed by patients in the community misrepresents the realities of mental illness. Individuals with mental health problems are demonised through this media-driven exaggeration of their dangerousness. Yet, in the felt experience of many of the users, the perception of violence or being subjected to a violent incident largely reflected the wider concerns that individuals have, for example, about living or working in an inner-city environment:

'Sometimes I don't like to come here in the winter, having to come out in the evening can be frightening, you read all these stories in the paper about women being attacked at night, and then there was that boy in

Liverpool ... when I come I make sure I can go home with someone else. There's safety in numbers.' (Service user)

There is clearly a role in the mental health ecosystem for a more responsible media presentation of mental illness. In terms of multi-agency approaches to mental health, a more positive reporting of health and social issues might reduce stigma, increase positive public awareness and enable individuals to access greater support services.

The advent of the proposed community treatment order (DoH, 1999b) would seem to suggest that a more effective model of teamworking will need to be developed, if feeding the media with sensational examples of violent and 'mad' people roaming the streets is to be curtailed.

Thus the national policy objective of achieving 'security', 'safety' and 'support' for the individual and wider society were transposed (at the individual level) into 'protection', 'coercion' and 'power over'. Compounding the problems that might arise from such experiences for service users is the way in which many mental health care professionals have continued to work in parallel with each other as members of a multiprofessional team, rather than achieving the more effective working together of the interprofessional team (Hiscock and Pearson, 1999). This results in independent practitioners, while masquerading as members of interdependent teams, continuing to practise in ethnocentric ways.

7.5 Dysfunctional teams

Many of the services in the case studies revealed a largely rhetorical approach to multiprofessional multi-agency working. Further we found that 83% of users were not aware that a team was caring for them, although 57% also claimed a clear idea of each team member's role. Some groups of staff remained largely 'invisible' to the rest of the team (psychologists), or appeared to exist in *'parallel universes'* (SWs). In the SWs' case, the sliding doors of access between each *'universe'* was constructed around the legal responsibilities of SWs, as they came into contact with the legal responsibilities of medical practitioners in the context of the CPA. In some instances, the data appeared to suggest both intentional and unintentional factors being invoked in justification for social action. In the example below the juxtaposition of perceptions of status (office allocation), ergonomics (office design, no privacy) and task (getting referrals and going) are used to justify poor teamworking experiences:

'It is a strange team, we all have the same focus and objectives and all have an equal contribution to make ... but some of us are more equal than others ... I have to share an office with two other CPNs and four support workers ... Hot desking is what our manager calls it!... However, both the psychologist and consultant [psychiatrist] have an office to themselves. Neither of them spends much time here. The OT has a cupboard but no office ... although she has a couple of big work areas. This place is supposed to be purpose-built but the accommodation is badly designed, we have no privacy and yet nowhere for us all to meet together say for coffee or something. Most of the time we just come in and get our messages and referrals and go out again.' (CPN)

In 1995 the Department of Health published *Building Bridges* (DoH/SSI, 1995), guidance on the statutory arrangements for interagency working between health and social services in the provision of care and protection of those individuals with SEMI problems. Four years later, the Social Service Inspectorate published *Still Building Bridges* (DoH/SSI, 1999), which indicated that little progress had been achieved between most health and social service teams. For example, the CPA is used in mental health care as the primary method of planning and monitoring of the individual's mental health needs, whereas in the social services, the CPA appears only as a sub-grouping of the more general care management (CM) approach for a much wider group of individuals seen to be vulnerable and in need of support. This shows how the economy of performance dominates a particular action (CPA) whereas in another part of

the system the ecology of practice supports particular actions (CM). (These concepts are explored in more depth later in the report.) This has implications for the role of the MHN as they move through the whole system, including:

- identification of the core goal (for example the establishment of an effective CPA process compared to interagency partnership working)
- actively working towards a shared or collective goal (viewing the CPA as an administrative task or using the CPA as an underpinning framework for action)
- ensuring the educational preparation 'best fits' the agreed task (undertaking the role of key worker or achieving synergy across a multiprofessional team).

Our data indicated that a polarised view was adopted by many MHNs over their involvement (passive or active) in the CPA, with 61% of respondents from the R&R survey saying that they lacked an effective CPA system:

> *'Trying to organise CPA meetings here is a joke. Dr S. doesn't agree with them and rarely turns up for meetings. No one will make a decision without him being here, so every thing gets left to the next meeting. The patient suffers and the staff get demotivated.'* (Social service employed CMHC manager)

> *'In this trust we have been told to use the CPA more, but it's more a paper exercise than a useful way of planning care, everyone uses it to cover their back.'* (Staff nurse)

These data also suggest the importance of considering the process aspects of care planning as a professional activity rather than just considering the structural elements of the CPA approach. Integration of the CPA and CM approaches has now become an NSF objective to be achieved by April 2001. Our data show that where it does work well, a joint initial assessment seems to be the key. In addition, the exercise was seen to be useful (rather than a paper exercise) and the team shared key-worker roles; i.e. the team member deemed to be most appropriate took on the role – CPN, OT, SW or doctor. The reasons for it not working well included a lack of GPs attending the meeting, and 53% of respondents from the R&R survey felt that there was a lack of value in the CPA process. (Recent studies by Kettles (1998) show that up to 40% of MHNs, particularly in the secondary care services, do not see the value of care plans or care planning.) This may be a reflection of the group of patients the CPA is aimed at (those with a SEMI problem), who may make extraordinary demands of the practitioner, particularly in relation to risk assessment. 62% of respondents from the R&R survey saw the MHN as the prime key worker in the CPA, and 69% of respondents felt that this provided the MHN with a clear identity within the mental health team. However, the overall implication is that the MHNs adopted co-ordinated or competitive strategies, rather than co-evolutionary strategies, with other team members in the way in which they approached the CPA process. This perhaps reflects the difference between whether the CPA was seen as being an individual (organisation) or a collective goal, and whether the predictability of outcome was seen as being high or low.

The implementation timetable for the NSF perhaps reflects these ambiguous perceptions and in some way recognises the difficulties involved in achieving effective multi-agency working. In the experience of our respondents there were many examples of few shared learning processes being used:

> *'It's not our role to help teach MHNs, that's what the colleges are there for. It might be useful for individual users to go into the classrooms and talk to students, but it's all a bit tokenistic and really the lecturers should be coming out to us.'* (Full time manager – regional user group)

> *'We have a new CMHC that's just about to be opened, but there is no money to support any team building activities ... I think all that will*

happen is all the bad ways of working will be transferred to a new building and no changes to the way we work will happen. After spending all that money on a new building it seems silly not to also spend some addressing new ways of working ...' (Ward manager)

'Despite the trust board declaring its support for greater patient involvement in their annual report, our patients' advocacy scheme has been developed without any real support from the trust board ... Sometimes you think all they [trust board] want is for you to get on with the job and not to worry about how you do it ... the means justifying the ends.' (Ward manager)

Implementation of the policies aimed at achieving greater integration is expedited through what has been termed *'centrally controlled devolution'* (Light, 1998). We argue that the centralist approach will not help reduce the dysfunctional nature of many multiprofessional teams, nor help increase multi-agency working. Our data provide a number of reasons for dysfunctional teamworking, including evidence of fragmentation due to poor team identity and/or strongly defended beliefs that teamwork exists, even where it does not. These findings were consistent across various teams in different clinical care settings, and with teams working in a range of different geographical and socio-economic situations. Overall, the data indicated that many team members had a poor understanding of the role of others, an inability to articulate their own role and even an explicit and unconcealed hostility towards other team members.

7.6 Integration and migration

Achieving integration within and across existing mental health teams appears to be problematical. At one level, policy guidance has provided a framework for integrated approaches between primary and secondary mental health care service providers. However, at the implementation level, if the guidance is not matched by leadership that facilitates an environment where challenge and innovation are allowed, then attempts at integration will fail. Stark divisions between both groups of practitioners were often the norm in our data. Achieving greater integration of CMHTs is an NSF objective to be achieved by April 2002 (i.e. achieving a 50% increase in integration of nurses working in secondary care and also the integration of other community workers, nurses, SWs and GPs).

'Sometimes I have made a home visit to a family where a health visitor has been in the morning, followed by me in the afternoon. Neither of us knew that the other one was involved with members of the same family. I have just started to go to the practice nurse meetings and we have started describing what kinds of things we do and what we do and don't have in common. Some of the practice nurses are quite reluctant to give regular depot medication, but maybe these nurse meetings might change that. It's to do with confidence and knowledge.' (CPN)

We believe that there are many other nursing groups working in primary health care that could undertake some aspects of the current roles of MHNs, such as practice nurses and district nurses (McFadyen et al., 1998). We have identified at least three important issues that are likely to inhibit the achievement of this policy objective:

- reluctance on the part of other primary care practitioners to become involved in direct clinical care of patients with a mental health problem (see also Ledwith, 1999)
- compartmentalisation of mental health nursing during general nurse training (see also Cohen, 1998)
- the heavy workloads which many primary care practitioners already carry.

Is such role sharing desirable? Integration of services might involve a range of unique processes, significant only within localities. In addition, the healthcare ecosystem is expanding

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and changing shape, for example, with the introduction and future development of the NHS Direct service.

> *'... if you feel low on a Sunday afternoon, you know really down, you can't get any help. GPs won't come out and see you, the hospital does want to know and A&E is too busy. In any case, you can't ring up 999 and say you are feeling depressed 'cos they wouldn't come ... I know that nurses and that need time off, but they should work out some form of rota which means there's always someone around ... I don't know what I would do without P. [partner] ... he is always there for me and I am one of the lucky ones.'* (Service user)

It appears at one level that greater integration could help in reducing these problems. However, largely rhetorical partnership arrangements are likely to jeopardise such progress. The enactment of the Health Act (DoH, 1999d) allows for health and social service resources to be used across service boundaries, but achieving this could be problematic. The consequences of different organisational cultures were experienced by many of our respondents:

> *'We have a team here and I am supposed to manage the whole team, but the consultant does his own thing, the SWs have responsibilities and ways of working that the Social Service decides, even the Group Workers were employed without me being involved ... Before we opened the centre we were all scattered over the city, even though we now all have this as our base, we might as well have not bothered.'* (CMHC manager)

Where multiprofessional teams worked well, the outcomes and perceptions of health described below were evident and embedded at the operational level:

> *'Although the actual team is small, just a consultant, three nurses and a secretary, we are part of a much bigger network of workers from health and voluntary sectors. We are independent of the wards and the community staff but we work with them. What makes us unique is that we seldom hang on to patients. Our role is very clear ... and so we assess, offer advice and refer to other services, sometimes we give emergency first aid. Most of our work comes from A&E or the oncology unit. We are called in when they have a patient who appears to have an underlying mental health problem, or where their physical condition has given rise to mental health problems. The fact that we know the limits of our role and what we are about has its down side as well ... sometimes we are asked to see someone whose needs could have been met by ward staff, but because it's mental health they call us in. Sometimes I think they have forgotten that part of being a good nurse is being able to listen to others! Anyway, it's the best job I've ever had. Our team is great and we work well together ... we are very supportive to each other and the other groups we work with see us as being reliable and we can be trusted ... I think we are more prepared to back each other up and that makes the difference!'*
> (Mental health liaison team nurse)

The NSF recognises the need to make a greater investment (£700 million) in the infrastructure of service provision. However, such public announcements are often misleading, with actual increases in resources being more modest, and resource allocation at the operational level remaining problematic. The policy guidance suggests that these changes should be managed through generalised 'shared vision' and 'collaborative' objectives, with accountability being to both NHS executive regional offices and social care regions.

7.7 Skilled workforce

The NSF (DoH, 1999a) acknowledges the need for mental health services to ensure that their workforce is sufficient and skilled, well led and supported. However, in the experience of some of our respondents this might be a difficult aim to achieve.

> *'I think that we [the nursing profession] have lost a lot in all these changes. Our career structure has gone, it can be difficult to move from E grade to anything above and then it's a case of dead-man's shoes. There aren't any opportunities anymore to get promoted unless you want to move around the country ... This trust knows that and although it tries to help with courses and things, a lot of the qualified staff have been replaced with HCAs. They are good, don't get me wrong, they have what I call an intuitive feel for the job, but there are limitations on what they can do compared to an experienced and qualified nurse. I think as we are having to change and adapt to what the Government wants, you know more community-based services, it will become more and more difficult because the skill mix has become so diluted that the pool of experience and skills will not be big enough to cope. I know what it's like out there in the community, that's where I came from.'* (Ward manager, acute admissions ward)

We believe the organisational and practice implications of the shrinking pool of skilled practitioners able to practise in a wide range of clinical setting will impact upon other policy objectives. Further, the perception of coercion, already seen in the context of CPA with some respondents, could lead to greater fragmentation rather than increased integration. This policy initiative, like so many others in mental health, appears to have been determined through a reliance on professional discourses.

Policy documents command different agencies to develop more partnership arrangements although they are never defined other than in structural ways. Such approaches should reflect the strengths of the local situation, but how this should be achieved is centrally determined. The element of choice and voluntary collaboration is replaced with an evidence-based argument based upon partnership exemplars and compulsion. The result is likely to see a shift to mental health service making responses to those more likely to cause trouble than those in trouble (Warne, 1999).

Policy rhetoric can have a powerful influence on practice. The following section explores these influences through the experiences of service providers, commissioners and managers across our case study sites.

Mohr's (1995) approach to critical appraisal of multidisciplinary teamwork in psychiatric care settings was particularly useful here. For example, we spent considerable amounts of time 'deconstructing' our observations of multiprofessional teamwork, reviewing the qualities of current practices by way of a *'hermeneutics of suspicion'* (Best and Kellner, 1991). Taking this approach, we gained significant insights into qualities of effective teamwork. We were also able to view some of the micro-practices that were perhaps implicit, but not necessarily appreciated by the team members.

8.1 Situating mental health nursing

We found it useful, when considering how to refer to mental health nursing practice, to return to the 50-year-old assumption that the core of psychiatric nursing practice involves the development of a *'relationship'* with the patient (Barker, 1998). In spite of the problematic nature of the term 'relationship', it is congruent with our ecological view of the mental health ecosystem. It allows for the location of MHNs, with other team members, and people who are using mental health services, and enables us to explore what constitutes the nurse's role.

The initial survey suggested the contradictory nature of MHNs' roles. For example, conflicts between the social control and care aspects of practice (Morrall, 1998) were noted. External pressures like national policy objectives and the allocation of resources have more influence on the actions of MHNs than the needs of the users. Considerations of the nature of the relationship between nurses and service users are inseparable from the contexts within which these relationships develop. Mental health nursing has been criticised for being too focused upon *'the patient as an individual'* – losing the broader socio-political perspective (Hopton, 1997). The nurse-patient relationship is a phenomenon that can be individualised to the point of being invisible, or unrecognised – having considerable implications for the value placed upon MHNs' work by policy makers. What we came to see as the 'situated ordinariness' of caring work was conveyed by many of our respondents:

> *'The role of the MHN? – they are housekeepers, they do everything else that nobody else wants'* (Third-year student nurse)
>
> *'The nurses are time fillers ... you know ... holding quizzes and that ...'* (OT)
>
> *'Well they [nurses] do the caring bits ... erm giving drugs ... er ... dressings ...'* (SW)

Further, while 'caring' was echoed on the one hand:

> *'The nurse comforts ... What the patient wants is a nurse they can relate to, a nurse who has a nice personality and, you know, can communicate at a very basic level and can instantly fit into that role of "professional friend".'* (Consultant)

Intervention skills (such as counselling) were also echoed:

> *'A lot of people we see do not want to be cared for ... I can't think of anyone I have nursed who has not started out being insulting and rude to me, and not wanting to know me as a person. [It's] just been awful. But then we have had this relationship and it has evolved. They [the patient] can confide in us, they can say things to us which they would not say at home.'* (Ward sister, acute)
>
> *'... establishing good relationships with the client, that is the biggest thing. Just being there.'* (Staff nurse, day hospital)

As was noted above, the R&R survey revealed strong agreement that the role of the MHN is increasingly problematic (84%). Part of the problem is locating where the MHN fits within the multiprofessional team. The survey indicated that although MHNs are multiprofessional workers (50% agreed), they lack the relevant skills and have a blurred role. In addition, while 46% of respondents believed that the MHN lacks relevant skills, they were unable to define what the skills were. Assessing and monitoring of mental state, and co-ordinating care, appeared to be the most often cited roles. This notion has been reviewed within specific practical contexts, in order to illustrate the theme of nurses' defensiveness and 'survival by camouflage'. The use of specialist skills as a self-preservation strategy linked to notions of professional boundaries of roles has been explored as a perennially relevant issue (e.g. Skidmore, 1994a).

We found that there was a sense that so much of nursing work was almost 'unsayable', an indescribable quality that would seem fairly congruent with the phenomenological presence required of the nurse-patient relationship.

> *'It is the being there thing ... we are with the patients 24 hours a day. Nobody wants to or does that.'* (Staff nurse, acute care)

> *'They always seem to be there, they are constant. Explaining to patients at an appropriate level, using communication skills I suppose. Their communication skills are lots better than SWs, slightly better than OTs.'*
> (Third-year student nurse on DipHE)

Our data showed that service users held both negative and positive perceptions of the existing roles of the MHN, both in the community and in hospitals. The positive descriptors used reflected a range of humanistic qualities that have been largely transposed into core competencies for the MHN (Sainsbury Centre for Mental Health, 1997), and included such notions as the 'good' MHN being supportive, understanding, encouraging, respecting the whole person, and having patience. However, in many cases, the counterpoint of these perceptions was a series of negative descriptors that appeared to be largely oppressive in both intent and outcome, and which would appear to suggest that some MHNs are not achieving these core competencies: *'forcing medication on you ... let's hold him down, let's inject him ... and act like heroes afterwards'*, *'they [MHNs] don't discuss anything ... make their own judgements ... impose their ideas on you'*, *'my CPN didn't stand up for me'*.

We found there was a related issue in how service users experience the nurse-patient relationship. Our survey results revealed some anomalies. For example, while 81% of the users who responded to our survey felt MHNs, in general, cared for patients, only 53% felt they could talk with the MHN, but perhaps more importantly, only 51% were sure who the MHN was. Indeed, comments from the R&R survey suggest that: *'patient needs are not necessarily a primary focus'* and that service users are not concerned with *'what discipline their worker is ...'*

Perceptions of the nurse's role, in relation to other practitioners, as well as in relation to people in their care, presented us with insights that were often reflected within the professional literature (e.g. Gijbels, 1995). However, the survey results present us with a paradox with regard to multiprofessional teamwork:

- 79% felt that they clearly understood their role within the team.
- 79% felt that they had a clear idea of each team member's role.
- 75% felt that their own role was clearly understood by others in the team.
- 72% felt their team to be effective.

The case studies illustrated less consensus and highlighted diversities of opinion with this particularly context-specific issue, and depended very much upon the practice setting.

'I wouldn't like to define it. It is a range of skills and abilities that are context determined. An acute MHN is a different creature from a CPN or a forensic nurse.' (MHN lecturer)

'The MHN is different in the community than on the ward. On the ward the roles are more defined, it needs to be. What do they do? They keywork, do paperwork, restrain, deal with medication, it comes down to a legal aspect.' (OT, day services)

Again, the paradox was reinforced by the R&R survey, where 64% felt that teamworking was made difficult by poor understanding of each other's roles. Many of the nurses reported ethical dilemmas which they faced daily as part of their role, such as in taking responsibility for multiprofessional team decisions. This responsibility could subsequently result in difficulties for nurses, when they attempted to convey potentially conflicting/difficult care decisions to service users. The nature of nursing work, with its inherent 'messiness' and sense of 'muddling through', meant that often nurses found they were having to be responsive and reactive to the demands of the wider environment. These demands reflected the growth in performance standards, characteristic of an emerging audit culture, which were noted in Chapter 7. These led to contradictions, as interventions based on safety, legal obligations and 'duty of care' meant considerable juggling of notions of 'care' and 'control'.

The tensions involved with this new emphasis were also evident within focus group discussions. For example, it became apparent that the nurses's role was perceived by some as being characterised by 'displacement', 'disenchantment' and 'disillusionment'. In the focus groups the changed culture and altered needs of people who use services were perceived by many MHNs to have led to their traditional skills no longer being relevant. This perception was pursued in the case studies, and raised a particularly sensitive question: What are nurses needed for?

'I think some people can turn up on day one and you could give them the qualification [of RMN] there and then. Some people develop skills. The skills of being a human being are most important, the others you can add on.' (Head of university health care studies department)

A number of issues were identified as being specific to particular environments. For example, the acute care settings we came across frequently bore out the difficulties inherent in 'being therapeutic'. Problems such as poor resources, staff (and management) attitudes and the *'fire-fighter'* mentality engendered in many staff (Tennant, 1997), often meant student MHNs were being socialised in ways that pressured them to 'fit in' and work in ways that compromised or indeed flew in the face of the ideal curriculum.

We saw further implications for the socialisation of student MHNs linked directly to acute care nursing. The sheer amount of time spent giving direct care by junior and less experienced staff had a significant impact upon students. Ryrie et al. (1998) also explored this issue, reporting on how qualified nurses' time was frequently taken up with administration, leaving junior staff working unsupervised. Further, considerable numbers of the students within our study gained much of their clinical experience working as 'bank staff' or 'agency staff' – unqualified health care support workers who were given significant responsibilities. The implications of this for how nurses work when qualified may be considerable. An additional factor, noted in Chapter 6, but which has particular resonance within acute care, is how nurses are socialised to balance caring, therapeutic endeavours, with the sometimes very real aspect of being in a position of power over clients (Porter, 1993; Glenister, 1997).

8.2 Resource issues

Resources contributed to how well individuals were able to define their role. Participants in the case studies returned to this theme frequently, both in terms of practical and educational implications:

> *'What happens in practice is that because of shortage of resources, if the CPN is going in to see someone, say once every two weeks, the SW will back off and say, "If he is going in, there is no need for me, I have my own case load". So the CPN more or less does the SW role and vice versa. But they do not actually acknowledge that. They say we have our defined role or whatever. But it is untrue ... The sources of the blurring is the pure lack of resources. They have to take on that role purely to get the job done. It is holistic care so they have to take on that role. They are also very protective of their own professional roles, so they don't want to have their profession hijacked.'* (Manager, voluntary organisation for MH)

In specialist services, such as forensic services, where resources were not stretched, role definitions were clear. We saw an example of excellent seamless service in a purpose-built mental health setting, housing an eight-bedded acute inpatient MH unit with the CMHT, which was very much multiprofessional. Individuals were much clearer about their role – the building allowed for regular discussions, partnership and collaborative working. On the other hand, we also experienced several CMHTs in poor areas with high drug and alcohol problems. The SW was several miles north and the OT was several miles east. Days and weeks would lapse before the professionals could connect – usually via letter and thus the CMHT tended to take on the role of a generic worker and help with benefits, etc. The lack of resources was discussed with a recently qualified staff nurse:

> Q: *'Thinking about the care you give to the clients, patients, and comparing it to when you were a nursing assistant, how would you say it has altered?'*
>
> A: *'I give less time – face-to-face time with them. Less time, to be quite honest. You have other people ringing up, you have doctors to spend time with, you have other bits and pieces, so you just don't have as much time. I try and make as much time, but you cannot always do it. On my shift I try and spend at least half an hour with them, but that slot is pushed.'*
>
> Q: *'So the people who spend the most time with the patient are the unqualified?'*
>
> A: *'Absolutely! Yeah! And the way you find out about things that are happening day to day on the ward is by ummm, because they come and tell you, you ask them and find out, you know.'*
>
> Q: *'Why do you think it has become like this?'*
>
> A: *'Because your job has become administering. You are in charge to get the day-to-day running of the place done, you know.'*

While a more experienced nurse commented:

> *'A GP wants someone who takes a lot of angst out of his surgery. Got the ability to do it. How do you train people to take on high amounts of emotion? Experienced practitioners have to make complex decisions ... what if the person hangs themselves? – it's down to me. How do you really prepare people for that? I don't think we prepare them at the moment. And we're certainly not helping our experienced practitioners to deal with that. Dealing with risk has got resource implications.'* (Acute MHN)

In addition we would argue that the construction of the role of the MHN within the multiprofessional team can be made more problematic by economic pressures.

> *'GPs do not see a priority in directing care to the severe mentally ill ... there's too many phobics demanding too much time ... what can I do? ... I'm part of this team but my brief is CPA ...'* (CPN)

If an economic rather than an ecological perspective is maintained, then perceptions like these may lead to a view of the MHN's role as being either generic (low cost, disparate skills) or specialist (high cost, expert skills). There is some credence given to this view (Peach, 1999) with competency determinates being developed to enable such pigeon holing. However, the adoption of a more ecological view allows for another way to emerge from the reductionist polarisation of the generic versus specialist school of thought.

8.3 The blurring of generic and specialist roles

The literature review suggested that because of the unclear role of contemporary MHNs, they would often escape into specialism. Our initial survey clearly indicates that there is a general feeling of a 'blurred' role for MHNs and this was reinforced by the R&R survey (66%). This was a recurring theme throughout the case studies:

> *'The role of the nurse today is blurred, indistinct. Things have changed so much it's difficult to say what it is.'* (MHN lecturer)

A picture emerged from our data of MHNs who experienced feelings of being undervalued, doing invisible work, doing work which 'specialists' don't do, the 'mopping up' work. Pre-registration students within the mental health branch spoke about this issue. They felt *'dissatisfied with the ways skills are taught, and under-prepared for autonomous practice'*. There was a sense that they hoped to learn the more specialist therapeutic work/skills after qualifying, but this meant difficulties articulating the reality of nursing, except in terms of 'learning the ropes'. This aspect was echoed in the R&R survey. Students were often unprepared for placements (88% agreed) and 80% agreed that skills education and training was inadequate. Further, a service manager commented:

> *'Once they qualify we have to start with the business of training them ... that wasn't an issue with the pre-P2000 syllabus ... they'd qualify and be able to land running ...'* (Service manager)

Some respondents referred to being *'pushed and pulled'* explicitly, with perceptions of *'about faces'* in policy directions having significant implications for their practice concerns. Many of the respondents noted that such changes were made more difficult due to the never-ending demands arising from having to respond to the organisational objectives, and the requirements of funding bodies and professional bodies:

> *'It's a bit like juggling ... you have to please your manager and the trust, you have to please clients, and at the same time as doing this, you have to keep yourself updated professionally.'* (CPN, substance misuse/community drug team)

A consequence for some is the sheer frustration of having to try to please everyone, and also the feeling of not being an autonomous practitioner to which they felt they ought to be aspiring. Our participants echoed Gijbels (1995), who discussed this in terms of being prevented from being therapeutic.

> *'Nurses these days are too busy, they spend most of the time doing paperwork ... Students I think are very poor generally. They are taught bad habits by the staff because usually they haven't been qualified that long and they pick up bad habits.'* (Nursing assistant, acute care)

Notions of the time nurses spend *'being around for clients'*, *'getting to know'* people, *'building the nurse-patient relationship'*, was something highly valued, yet also, perceived as being generalist, indeterminate. The idea of indeterminate practice, being responsive/reactive rather than skilled in specific therapeutic interventions will be revisited later, as there are many economic and ecological implications of this issue. Some of these relate to the need for diversity in philosophical approaches to care within mental health care practice, as well as issues relating to demands for evidence-based practice.

8.4 Multiprofessionalism

We found that multiprofessional team dynamics were perceived to be complex, multifaceted and steeped in unstated assumptions. There were assumptions about:

- shared goals
- appropriate care delivery
- issues of belonging to the team
- speaking across boundaries
- the ability to convey one's own professional integrity.

Some of these assumptions were identified in the initial survey and the R&R survey.

Since we also found some illustrations of good teamwork in 'poor situations', these aspects are perhaps put forward in an attempt to sanitise the situation. A more significant issue may be tribalism (Beattie, 1995). How different team members perceived each other was noted as being a recurring theme/issue, which was linked to notions of 'effective relationships' between individuals in the team. Issues of professional identity, relating to how one 'becomes' a particular kind of mental health practitioner, were explored in terms of how one is educated, both formally and as part of professional and organisational socialisation processes. Some of the implications of these issues – differences in use of language, knowledge base assumptions and hierarchical factors concerned with the perceived value of the specific therapeutic contribution – all made an impact upon how practitioners viewed each other.

> *'People do worry about marking their own territory and worry more about this than the patient.'* (Lecturer and CPN)

According to some respondents, learning one's own identity – 'becoming an MHN' – needed to be achieved before learning to be part of a multiprofessional team could occur:

> *'Pre-reg. is not about preparing people for multiprofessional working – we talk about it, other people's roles … get other professionals in to talk with them, but they are not immersed in the culture of other professionals. It's noticeable when you co-teach a module with another profession. Some we teach with Social Work, and they have a different feel, it's about the substance abuse, child abuse, but with a slightly different emphasis.'*
> (MHN lecturer)

Further issues of trust, security with one's position within the MDT, and feelings of belonging and having one's skills recognised, became linked with our understandings of 'tribalism' as an important 'layer' of meaning for people within the team. For some professionals, it was difficult to see beyond their own role remit, with stereotypical ideas being used as a kind of shorthand. Thus SWs were characterised as being concerned with benefits and housing, nurses gave the medication, and OTs assessed 'living skills'. These ideas pervaded both clinical care and educational settings, although when explored further, overlaps in skills were often conceded. The effects of stereotyping were evident within many of the teams, particularly where much of the teamwork remained at the rhetorical level:

'I think one of the comments that we've had in the past is "Oh, you're the nurses, you deal with medication don't you?" – and I think that's just a small part of our role. I hate giving depots, it's just a sideline … another is, nurses don't do groups, that's an OT role.' (Staff nurse, day unit)

Predictably, the use of stereotypes for the roles of SWs and psychologists seemed to be more evident when these practitioners were not present, or somehow unavailable or inaccessible to the team. Where there was a more realistic awareness of others' roles with more of a willingness to share skills, this seemed to develop the ability to 'get on with' other team members, in a professional sense (respect for the other, difference, etc.) as well as on a more personal level (knowing/caring about each other, going on team building and social events). While this was generally perceived as a strength of the team, it also had the effect of perhaps getting in the way of effective teamwork, particularly if friendship allegiances came before the professional values of the group.

'The biggest influence on the way I work now is because of the influences I did have as a registrar. I worked in an MDT back then and the psychiatrist was a fascist – and he had a personality disorder in my opinion – and his personality got in the way of smooth routine working. I remember that experience and it is with me now.' (Consultant)

While team members other than nurses may often have had a clearer sense of identity, sometimes overlapping skills could give rise to jealousies, resentments, suspicion and conflict:

'I think problems happen when some staff feel they are more skilled but won't share – if they keep things to themselves.' (Staff nurse, specialist service)

'… how she [the nurse] would teach him to iron would not be the way I would teach him … I wouldn't let her … that's my role.' (OT, day hospital)

We would argue that the professional protectiveness that we encountered is inextricably tied up with perceptions of roles, expertise, and issues of difference. These feelings of professional defensiveness often led to MHNs and other team members trying to improve their professional development, with a 'scramble' to get on programmes being apparent, although practitioners often seemed to be unaware of wider policy and education objectives.

8.5 Looking for credibility

Education, at post-registration level, was perceived by some MHNs as giving a sense of validation. Even though they may have 'picked up' skills more informally, developing expertise through experience, there was a sense that 'having the course' legitimated nurses' sense of competence. For example, one respondent, on completing a 'Multiprofessional Teamwork' programme, reported that she: *'had not learnt anything new'*, but was reassured in her own knowledge that she *'wasn't missing anything'*:

'Yeah, there is room for more training, PSI training would be great, I did a taster which … made me feel more able to do something specific, really pleased, gave structure … again, you knew some of it already, but you didn't have any structure to it … Reassuring of what I knew, gave me a more tight way of working.' (Staff nurse, day hospital)

Some of the post-registration programmes were perceived as a panacea for MHNs, a relief from indeterminacy, but there was often a subsequent feeling of *'Emperor's new clothes'* (Skidmore, 1994a) when the realisation dawned that they needed more than this in order to facilitate continued, ethically appropriate, mental health care within effective, contemporary multiprofessional teams. The trends and fashions, 'hot issues', seem to meet practitioner needs, but it is almost as though MHNs in the 'firing line' need whatever defences they feel are on offer, taking on board whatever is there, to adapt to contemporary demand.

On exploring approaches to multiprofessional education, we gained the impression that nurses may be relieved to gain a foothold into more specific skills-orientated practice interventions. Participants described how a lack of opportunities for career development promotion meant education was being used to gain status within the team:

> *'... in a way people are trapped, there are people who have been staff nurses for seven years, that I know of... which was, like, unheard of, when I trained 20 years ago. I think one of the interesting things about this is that people are beginning to adopt other strategies, beginning to look at developing their clinical practice, and their skills, as a way of maintaining their motivation, and status might come from skills rather than financial remuneration, because you are still an E Grade ...'* (MHN lecturer)

Practitioners expressed frustration at the institutional agendas, the lack of coherent educational strategy on the part of service providers, with professional bodies, such as the UKCC and the Board, being seen to have little say. Because, perhaps, the perception within clinical contexts gives nurses the idea that *'it's up to individual practitioners'*, this leaves a sense that professional autonomy is two-edged and, at times, problematical.

> *'I'd love to know because I haven't managed to ... where do I find the information from? We don't get anything sent to the ward, or if we do we don't see it.'* (Staff nurse, acute services)

> *'When you look at it there is very little available for staff. There is a lack of expertise for any basic human and interpersonal skills. We have the A61 ... but have you seen the curriculum? What on earth are they doing putting drama therapy in there, it's not appropriate! We need courses that are accessible and relevant. If that means one of my staff wants to do the A60 that's fine, there are definitely things in there we can use ...'*
> (Ward manager, acute services)

> *'It depends on where your interests lie, but the problem is that you might have lots of people who are interested in what's current, PSI, CBT, because it's trendy, it's in the literature, what's the current language. If you want to be cynical about it, four years ago, the big thing was clinical supervision; it's now fallen off everyone's agenda, now it's risk, in all its manifestations.'* (MHN lecturer)

One message here seems to be that 'appropriate' education and professional development is almost a luxury, or superfluous to the demands of practice. Interestingly, this issue was raised primarily by nurses in acute care, the setting that is only beginning to be recognised as being in need of development. Our data from nurses working in CMHTs and more specialist services, with arguably better resources, seemed well equipped with the appropriate specialist skills programmes.

However, we conclude that post-registration education has been a strength for many MHNs. The development of specific clinical interests for individual practitioners, contributing to practice development and producing research that can be used to support interventions, was apparent, as was the sense of worth from gaining recognition, being heard within the team and by peers at conferences.

8.6 Teamworking in practice

We found a tendency to view effective or ineffective teams as being situated somewhere along a continuum of 'good or bad', 'rigid or flexible', 'organic or mechanistic', reflecting organisational experts such as Handy (1975). This was not a surprising outcome given the exposure to the pernicious effects of the economy of performance approach many of the respondents had experienced. To a lesser extent, some respondents saw multiprofessional teams

as being constructed around core and periphery workers (see also Miller et al., 1999) and identified effective integrated working at one end of a spectrum, and fragmented ineffective working at the other, the middle point being an aspect of balance arising from shared role expectations and care delivery.

> *'I think the MDT here is good for three key reasons, the willingness to work as an MDT, here that's engendered by the consultant giving his own power up; the ability to appreciate generic areas and willing to work in these areas without being sucked into historical professional roles; and the well-developed internal structures for taking referrals, a mechanism to access specialist skills.'* (Lecturer-practitioner)

> *'The key features of effective MDTs are respect from all disciplines, and good communication ... here we have regular morning meetings that include OT, nurses, clerical staff and myself, and sometimes the consultant or the SW.'* (Staff-grade psychiatrist, specialist service)

The concept of the ineffective team, unsurprisingly, consisted of responses opposite to those held for the effective team. For example, in the R&R survey, it was recognised that issues such as poor communication (96% agree); lack of a common goal (71% agree); differing personalities (71% agree) and being inflexible (61% agree) contributed to ineffective teamwork:

> *'Ordering people to work together doesn't work, everyone just nods, yes sir, and continues in their own sweet way ... I've never come across a psychiatrist who has taken the blindest bit of notice of us ... you can put in a report, put it in black and white and still be ignored.'* (CPN)

> *'Where do you want me to begin [about ineffective MDTs]? ... we don't talk, don't do, don't share, don't listen, don't care basically. In the acute area it's you as the nurse with the doctor and the OT ... if you're really lucky, an SW might be caught in the building, but that's a rare and precious occasion.'* (Charge nurse, acute admission ward)

Communication – talking *and* listening – appears to be the central component as to whether a team functions effectively or not. We argue that these problems stem, in part, from differences in the use of language and the prevailing ideological discourse, particularly between psychiatrists and nurses. Gallop (1997) would appear to support our argument. She suggests that epistemological differences – between the language of science, objectivity, diagnoses and the language of relationships, feelings, context, process – may be instrumental in the silencing of nurses', and indeed, users' voices. In addition, we note that some respondents' 'real world' of practice and the ideology of effective teamwork do not match. This ideology-reality gap (or perhaps expectation-reality gap, particularly for students and new staff) or the rhetoric-reality gap (for the assumptions in policy and educational documents and how this is distorted in the prism of practice) was evident across the case study sites and within and across different professional groups:

> *'Well I've met it in the classroom [MDTs], but its got bugger all to do with what I see ... I think that the classroom experience is useful because it gives you the ideal ... it's something you can adapt or build upon once you start in practice.'* (Third-year student MHN)

> *'I only ever meet the MDT in practice ... we've had an assignment on it. The skills centre around communication, assertiveness ... understanding where other people are coming from. There does seem to be this assumption that everyone does it and knows what it is.'* (Post-registration student)

> *'It's through role modelling [learning about MDTs]. It only came together over a few years once I was working in acute psychiatry. I don't think it's*

something that can be put down on paper except in general terms ... do it to learn it.' (Staff nurse, day services)

However, it was also common for respondents to give a list of positive features of teamworking and consider that their team was effective, but then to point to problems that existed within their teams:

'Yes, we are effective at what we do, I suppose. We do have a problem with communication though. Some people will pass information on, but others, well I don't know ... they keep it to their chests.' (Staff nurse, acute admission ward)

'We work well as a team because we know each other and get on together. I know what my strengths are, and I know what Sally's or Barbara's are as well ... I do think that the nurses perhaps don't really know what I do, and there can be a little friction when they ask me to deal with a housing benefit form.' (Approved social worker (ASW))

'Oh yes, we really do work well here ... everybody has their say, but not everyone will agree though. I can ask the SW what they think when they are here, but it can be a problem getting them here sometimes ... it can be difficult.' (Senior house officer, acute psychiatry)

'The consultant and the OT always attend ... sometimes the psychologist ... everyone has a 72-hour assessment by the OT ... well the 72-hour assessment doesn't always happen ... It is meant to be joint, I think ... frankly it can be problem getting an OT.' (Staff nurse, acute admission area)

We found that often practitioners, managers and users gave differing accounts, the managers assuming good teamworking, but this being denied by staff in junior positions:

'Management? They don't know their arse from their elbow that lot. [Manager], she's OK, she at least comes when we need her ... the others you can't see for sick notes [laughs].' (Care worker)

'Well I had this pep talk from [manager] and nothing matches what was said ... staff are really despondent, the consultant is an arrogant sod, and some staff hate each other's guts ... thank God all teams aren't like this or I'd jack tomorrow.' (Student nurse)

While we welcomed the examples of excellence we found, we suggest this was not the norm. A clear discrepancy between the theoretical concept of effective teams and the teams which exist in practice was evident in our data. While many teams may not have been as effective as they wished, they at least recognised their failings. However, we found an alarming number of teams which were clearly struggling to function effectively, but were claimed to be effective by team members and, perhaps most worryingly, by managers.

Many respondents saw the requirements of a good multiprofessional team as being no different from that of any other team. These perhaps reflect skills that are often thought to be better 'caught' than 'taught'. The next chapter examines these issues, and those already noted in other aspects, as the respondents in the case study sites experienced the educational preparation for practice of MHNs.

While the remit of the study was to look at the education and training of MHNs for multiprofessional multi-agency teamworking, we believe wider educational issues must be considered.

We begin by exploring beliefs with respect to who should 'lead' the curriculum:

- students
- practice
- educators
- users and carers.

Everyone agreed *'it needs to be a flexible model'*. It also represented *'the aspirations of the Government'* particularly as an emphasis on accountability was *'enshrined within this notion of protecting the public'*. A problem was, however, that *'clinical practice ought to be sure what it wants and it isn't'*.

9.1 Competition and co-operation

In Chapter 2 we suggested that the tension between competition and collaboration creates turbulence in the policy arena. In particular, a professional model based on open and shared access to strategic and disciplinary knowledge is in conflict with closed and competitive tendering for programme funding (see Chapter 4). In the field we found suspicion, threat, lack of co-operation and the absence of real partnership. We often encountered what we called the 'round robin of blame', played between students, HE lecturers, practitioners, service managers, politicians and researchers. For example, the students often blamed poor achievement on the lecturers for teaching *'above their heads'*, and/or practitioners for being too busy to spend time with them in the service areas:

> *'When we go out into placements we are the bringers of bad news. We come with all this theory. They say, "We don't do that here". When we come back here (university) and hand in our assignments they say, "Oh that is not right, we don't operate like that here". So wherever we go we are just bad news.'* (Pre-registration diploma student)

> Q: *'OK, so you would say the education is out of touch with the practice, but would you also say that practice was out of touch with the education?'*

> A: *'Yes [group voice]. They don't know what we are doing here' ... 'many wards do not want students on' ... 'you aren't treated right. They are not interested with what you are learning at college. It is like what the psychiatrist says goes, that's it.'* (Pre-registration diploma students)

Further, negative feedback received by lecturers was blamed on the practice area for not providing adequate opportunities for putting theory into practice.

> *'Due to the lack of qualified staff, the pressure and stress increase in practice, motivation decreases. Therefore, although most still believe in the "ideal", they are unable to fulfil it.'* (Lecturer)

We found that many practitioners retaliated by blaming HE lecturers for not teaching relevant and realistic content which could be used in the practice areas:

> *'The CFP – mixing the different types of nurses together – is a mistake. They do not need some of the knowledge they are getting. They will never*

use it in practice. It is a waste of time. The placements are not structured right. They only have a day or two here and there. They are supposed to build up a relationship with a patient. How can they, when it is structured like this? No one has come over from the school to discuss this with us. It is difficult to talk with the school. There are not enough links with us and the school. I would like to go in to the school and talk with them. They have not taken me up on it.' (Manager, acute ward)

This blame culture results in individuals painting a distorted picture that fits their existing perceptions. An equally distorted picture is painted, however, when the resulting turbulence is spirited away in invocations of the ideal – chants of partnership, teamwork, collaboration and co-operation can be heard – sometimes a resolution to what might need to be read as irresolvable.

'The tripartite system works very well when all three can get together as planned ... there is not really a hierarchy and that works well. If there was a hierarchy then the student would be placed "below" the practice assessor and the lecturer. The latter two are usually on an equal footing. It is rare when it does not work very well. Learning contracts are made and the students can write their own practice outcomes. We write the pathway outcomes.' (Principal lecturer, MH)

A student at the same university commented:

'The tripartite system never works. It is very unusual to get the three people together in the same room. Usually someone can't make it.'
(Post-registration student)

In another example, a CPN was describing how her multiprofessional team was working quite well now that they had a permanent consultant. However, later in the conversation she commented:

'I often do SW things because the clients often don't want the stigma attached to having the social services involved, especially if there are kiddies in the house – the social services are a no-go area. If I can do it, then why not? Anyway we only have one SW and it would take a year and a half before they can see people. It is easier just to do it yourself. It is quicker and you know what is going on, especially if you are the key worker.' (CPN)

Participants in the R&R survey unanimously agreed that partnerships between educators and service professionals, users and voluntary agencies would improve educational programmes. However, 85% felt that such partnerships would be difficult to achieve, mainly because of differing agenda, but also because of an element of competition between these groups:

'There is a huge gap between social services and health – still. When you first look, yes, they are starting to work in teams, but under the surface people are struggling to define their role. CPNs are doing exactly the same job as SWs and I would say there is a huge blurring of the roles all over the place, same with consultant psychiatrists. Where does their role begin and end? ... Certainly, there is a lot of friction between psychiatrist and SW, because consultant psychiatrists have the overall care for someone, but ... the responsibility lies with the SW to monitor things when they [the client] are discharged in the community, you know to monitor things.'
(Manager, MH voluntary organisation)

Thus, at the individual level of the multiprofessional group, similar competitive tensions invest an ostensibly collaborative rationale, with its equalising language of 'partnership'.

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As Miller et al. have recently pointed out, such interactions include *'the effects of competing prioritisation of work by team members'* (1999: 147) and students need to be able to understand these pressures against cohesion.

Bearing in mind our curricular analysis, a number of implications for teamworking are evident. Where teamwork was mentioned in the documents it was done so in an idealistic way and contextual realities such as blame cultures were not addressed. Our survey findings also highlighted that a large majority of respondents in the service and education surveys felt students were not prepared for their placements and indeed did not feel pre-registration programmes, in particular, provided students with a good grounding in multiprofessional teamworking. Issues of competition versus co-operation may also have a significant impact on how students are socialised into teamworking. We believe that to some extent a competitive and economic culture reinforces professional tribalism and ineffective teamworking. However, we are not suggesting that the resulting 'messiness' can be wholly removed; but perhaps it can be better understood and addressed.

9.2 Standardisation versus differentiation

In Chapter 4 we suggested a further tension between 'top-down' programme design and 'bottom-up' initiatives. While the DoH, UKCC and Board offer guidelines and prescriptions, they also state that they want service users, service professionals and educators to work in partnership to develop and deliver education and training to meet local needs. Added to the top-down pressure are the HE constraints, as described by this lecturer:

> *'I have just finished writing a curriculum document for mental health. I felt quite guilty when you were talking because I have been busy reading all the latest policy documents and I was very consciously trying to get into the curriculum all the language. I was very conscious I was writing for an audience – the audience in the university. We consciously decided not to include the Board because we felt it would be too much hassle. Thus we were picking our audience. I don't like the idea of persuading people through your rhetoric, it seems disingenuous. But it is a game which needs to be played in HE.'* (MH lecturer)

Bottom-up initiatives such as user and service involvement, student-centred learning and partnership in education were more elusive in our data. For example, a lecturer who had been responsible for writing the curricular document for a post-registration programme was asked to explain the 'consultation process' he was referring to:

> *'We have consultations with them as to what they want. This takes place in workshops. To be honest (and there is no reason why I shouldn't) we consult them after we have written the document. But we do change things after consulting with them.'* (Principal lecturer)

This illustrates the limited extent of equality evident in pursuing collaboration – merely letting the other person 'have a say'. The same person also commented; *'It is hard, isn't it, cos you kind of take ownership of the document don't you?'* This is interesting, since *'ownership'* can imply possessiveness. Later he states; *'It is often me going over to them, but not always'*, perhaps signalling an imbalance, that is, the lecturer is in 'advocacy' mode.

Further, a lecturer talked about her teaching approach as being *'empowering'*, *'integral'*, *'radical'*. She wanted students to *'come up to me and say I have read this. Argue with you'*. This suggests that students don't currently do so, and maybe they are not empowered in any sense that they would recognise. This sentiment was echoed by a student when discussing the curriculum documents which they received:

> *'The words are meaningless. I just don't understand those documents – they are full of jargon. The words mean something different to everyone.*

They [the lecturers] say go away and see what the words mean to you. We don't know what they mean.'

Another added:

'The slogans "learning for life", etc., they are just that – slogans.'
(Second-year pre-registration students)

This issue of standardisation and differentiation threw up a number of interesting issues:

- to what degree does standardisation already exist in programmes?
- to what extent is it desirable?
- in what ways are issues of standards invoked?
- what degree of homogeneity/diversity can be considered optimal, given the care needs of the population?

We argue that in adopting such an 'economic approach', questions of what should/could be standardised and what should/could not, in the planning and delivery of MHN training, is thrown into sharp relief. For example, a post-registration lecturer commented:

'We need standardisation. If we do not have standardisation, then how the hell can we keep up our professional image? We should have a body somewhere who says, "Here is your A51. Here are your core themes, and this is what the content should look like, these are your aims. You can mix and match some things and teach it in different ways, but you must have basic standardisation." I did the 945 rehabilitation course. I had five choices of where to take it. What was the difference? "x" was behavioural, someone else was total economy, "y" was humanistic (that sounds sexy). But they are all doing rehabilitation and they are all philosophically different, how can it EVEN BE APPROVED??! Courses under one title, one number were just so different!!! I think it is because the institutions still call the shots.' (Lecturer, forensic MH)

This illustrates the tension involved in deciding how desirable a more homogenous provision is, given the turbulent nature of the practice ecosystem. R&R survey respondents agreed that the curriculum should be more standardised nationally (71%), but interestingly 78% agreed that a more varied curriculum should/would help MH nursing to progress. As mentioned in Chapter 8, a similar discrepancy became apparent when respondents were asked about the merits of the generic worker versus the more specialist mental health professional. Reconciling such disparate views can be difficult.

Many respondents assumed that different models of specialist practice programmes should not be approved, simply because they differed. Explicitly, it was a question of rationality: all *'the Board's specialist courses'* should cover the same ground in similar ways. More implicitly, it was a question of standards. How could the same qualification be granted to individuals on the basis of different experiences? The current drive towards the homogenisation of provision is powerful, but it carries dangers in terms of national over-specification. We suggest that it is unhelpful to believe there is one 'true course' for generic or specialist MH nursing. We argue that diversity is a positive value in itself, both in terms of national provision and in terms of the sense of ownership and the identity it gives to those who devise it and teach on it, as opposed to those who merely 'deliver' a 'national curriculum'.

The Board's guidelines were designed to be enabling and, as the quotation above and as the curricular analysis illustrate, very different models of programmes have appeared on paper. However, it is important to note that programme philosophies are 'marketing' documents in the competitive tendering world. We found little evidence in modularised programme provision that individual lecturers responsible for single modules knew or cared very much

about the overall rationale: *'Joe writes that stuff [educational philosophy of the programme]. He is into that curriculum stuff.'* (MH Lecturer)

In addition, we came across little evidence that staff development had targeted programme philosophy and concluded that there was a radical disjunction between overall programme rationales and modular provision. Modular provision seemed to be more standardised than the overall programme. Individual module lecturers had often been provided with a 'shopping list' of headings, under which to write the modular aims and objectives, teaching strategies, content, learning outcomes and so on. These somewhat *'flat documents'* had little space for creativity in terms of multidimensional philosophical and pedagogical approaches. A further disjunction was apparent between the *'flat document'* and what was actually taught in the classroom. Lecturers often acknowledged that either they didn't know what was written in the module document because they did not write it: *'I'm not sure, I just teach what I want and feel is appropriate'* (MH Lecturer) or they had forgotten what it was they had written.

9.3 Role definition versus role diffusion

A third tension, noted in Chapter 4, concerns the loose couplings between policy and educational rhetoric. We argue that the practice-related, holistic, developmental and empowering rhetoric of most of the curricula analysed ('competence', 'reflection', 'experience', 'evidence', 'skills', 'relationship' and so on), are developmental terms that are hard to realise in the context of a modularised and rather fragmented HE context. Similarly, in the curricular documents, the student is envisaged as a 'reflective practitioner' or 'research-based' professional. However, our case study data reveal that the realities of ward life deny much opportunity for reflection or research, leaving the student in the placement as a rather bemused and under-skilled onlooker. (This is also evident from the survey data.) Our case study data highlight that students on placement use a different type of rhetoric, for example; *'incompetent', 'lacking skills', 'survival', 'having no time for reflection', 'scared', 'intimidated', 'lacking confidence', 'jumping through hoops to get a good assessment'* and so on.

While accepting that these might be overdrawn contrasts, the data we gathered did suggest that the student was cast in a number of different roles where they sometimes found it difficult to learn – at least at the pre-registration stage:

> *'I was so scared when I went out on placement – still am! You just like sit there and feel like a spare part. They [the nurses] tell you to go over and talk to the patients and I like say "right" but I don't know what to say. One said to me, "Are you a student?" and I said, "Yes" and that was about it. We sat and watched the telly.'* (Pre-registration student, end of second year)

We also noted that many students were influenced by participating in (in)effective teams, learning through doing and reflective analysis with insightful mentors:

> *'An example of a bad placement would be a ward I was just on really. I was only there for four weeks, a day or so a week, and I just felt that I was ignored, that I couldn't do anything.'* (First-year student nurse)

> *'Through my course I feel that I've had fairly poor placements. I'd done acutes previously but didn't feel welcomed, the staff didn't involve me. They were too busy. In this area it feels more settled, I feel as though I'm more a part of the team, because I'm more accepted, but I am almost qualified.'*
> (Third-year student nurse)

It was noticeable that mature entrants had fewer problems with these transitions than younger recruits. They often appeared to appreciate the idealism inherent in the education. They were aware of 'what is' out in practice and expressed more of a need to understand 'what could be' or indeed 'what should be' in relation to caring for individuals with mental health distress:

'I think you need to know about the person, in order to treat them holistically and I think it is up to us to make the link from theory to practice.' ('Mature' pre-registration student)

However, the first few months in post after qualifying appeared to be more stressful than training, since they had the added burden of responsibility and accountability:

'For the first four months in this job I was like floundering. It was the worse four months of my life. I had had loads and loads of experience in MH as a support worker. I knew what mental illness was and liked the importance of communication – different ways to communicate – and I was still floundering. I thought do I really want to be a nurse, because there was such a massive gap between being a student and being a nurse. You know it is to do with responsibility and things you did not know and could not know until you were qualified.'

Q: *'Can you give me an example of when you really felt anxious?'*

A: *'Medication. It was purely because you know you are on this shift, you do the tablets. I didn't know what I was giving to the person. I was on nights and this guy was on this medication. I have given him it, but an hour or so later he was asking for some more. I didn't know whether I could give him some more or something else. I didn't know. I knew who was upstairs and I knew she was very experienced nurse so I rang her and asked her. But I did not know and it was really awful, you know, you are giving this medication to someone ...'* (Staff nurse, acute)

A recently qualified MHN working in an acute inpatient unit reflected on her training:

'It is all taught in such an abstract way. I didn't learn anything. What I learned was as a support worker prior to my training. They [the lecturers] say, "Here are the books. Read this." But the books can't teach you if you have not understood what you are reading about.' (Staff nurse, acute)

Nor did the role of the MHN, its possible future development, the way in which the role is refined, and the extent to which it has become diffused, offer great clarity to the student MHNs. Currently professional knowledge and skill acquisition is facilitated through segregated programmes. We believe this could add to the confusion and contradiction over roles and expectations. Even within nurse education, segregation at the pre-registration stage can result in barriers to coherent practice being reinforced early in the nurse's experience. As was noted in Chapters 7 and 8, the MHN's identity is in crisis – unable to be easily defined:

'It is not like the ward where you've got definite routines, everything is very much built around the client. It is what is in the diary. You then work your own work schedule depending what is in the diary. So a student would find it hard really to understand the role and what you do.' (CPN)

Some respondents made valiant attempts to trace the 'career' of the role of the MHN through various psychosocial phases into a stage where the MHN began to reject the title 'nurse' in favour of that of 'therapist'. However, the role always seemed to be in *'a state of flux'*, although often centred on the implementation of the CPA. One outcome might be the generic health worker, although many MHNs *'are very uncomfortable with the changed context'* and were *'trying to hold on to values they might have had five years ago'* (Manager). In Chapter 8 we gave examples of 'role descriptors' for MHNs – takes the responsibility for the CPA, is on call 24 hours, seven days, does the 'bottom-line' care, gets what's left over and so on. In the diffuse version of the role, is the 'depot' the only sure-fire marker of MHN identity?

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'We work closely with SW – say on a weekly basis, but they are moving here when we get the building sorted out. I talk to them over care plans. We meet over the CPA process. I do not ring them for advice. They do not deal with benefits or housing, they don't do that now.'

Q: *'What do they do now?'*

A: *'Well, they tell me they do psychotherapy, counselling ...'*

Q: *'Do you think you do that also?'*

A: *'Certainly do. Counselling group activities that sort of thing, yeah, we do. I think they are moving into our realm. We also have a problem getting SW for certain things. You know you have to get the right wording on letters and things.'*

Q: *'What do you think SWs would say to me if I asked them what they think you do?'*

A: *'Well we look after people don't we? [Respondent role-plays being an SW] You know like in hospital and we [the SW] can dump our patients on them when they are causing problems. [Out of role] They probably see us as doing group work, 24-hour care and maybe counselling ... They would not see us as doing benefits and housing – they do not do it, so why should we? The agencies are for that. We have different things to offer than SW. For one thing they seem to lack insight into MH training, as to the voluntary agencies. We are basically in the business of delivering care. We would not let a patient with schizophrenia lay in bed and not get washed and dressed and fed, you know. We care for basic needs as well as complex needs ... They would just care for the complex needs and would not be interested in basic needs.'* (Manager, day centre)

The conflict between role definition and role diffusion again highlights the problems of the turbulent context in which mental health care and teamwork are situated. The incongruence between the role of the nurse as defined in policy and educational documents and that role as experienced by the nurses and students in our case studies highlights the difficulty in teaching for and about the role. In our initial survey, many respondents said that multiprofessional skills are not effectively taught in the classroom and that placements where they may learn these skills were too short and disjointed. This issue is revisited in Chapter 11.

In relation to post-registration education and training, resources were frequently mentioned as a barrier to professional development:

'You can be idealistic about what courses you want, but it all boils down to money. I'm running aggression management courses and it's difficult to fill the places because staff can't be spared from the wards. I consider that mandatory training.' (Lecturer)

Many managers believed politicians are now trying to forge post-basic education without proper manpower at ward level, to allow people to go and develop:

'We haven't got that in our financial infrastructure at ward level to go and do that. You can track it back to P2000. The money has gone and it's not going to come back.' (Manager, MH services)

We argue that resources can dictate the role and what can be/is performed. Resources directly affect education, especially at the post-registration level. Further, Miller et al. (1999) have also questioned whether shared learning had resource issues built into its rationale. For example, it is clearly more cost effective to have large classes *'there were 200-300 people in the room – it was horrendous'* (Post-registration student). Thus, what we have here is a 'resource-

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practice gap' and a 'resource-education gap', which complicates the problems inherent in the 'theory-practice gap'. The latter, however, was also expressed in the context of learners in terms of 'ward cred'.

9.4 'Ward cred'

Students at all levels repeatedly mentioned the importance of 'ward cred'. Lecturers need to be seen by the student to know what they are talking about, to be credible and to apply the theory to practical situations drawn from current experience.

'The tutors who are spending one day a week in practice operate much better than those who have not been in practice for years. You can see the difference, it is conspicuous who is in practice and who is not, with these tutors.'

Q: *'How? Can you give me an example?'*

A: *'They are more realistic in what they expect you to do and what they ask you to do. If we say, "This is not happening", they are able to say, "Yeah I know", whereas those tutors who are not in practice argue with you.' (Pre-registration diploma student)*

'Paul's knowledge about the subject is excellent. He is really passionate about what he does. I have worked with him and he is just the same in practice. He really stimulates us.' (Post-registration student)

As opposed to:

'The tutors were trying to be forward thinking, but it wasn't realistic. It's different on the ward.' (Manager with much post-registration education experience)

Students were not the only ones to recognise the importance of 'ward cred'. In one particular case study, several lecturers took seriously the 20% suggested time allocation by the Board for working in clinical practice:

'I am very, very concerned that I maintain my 20% and I am concerned that the team [CMHT she worked with during that time] do not see it as tokenistic. It makes me irritated when I hear people think that we (as educators) are coming in and doing the people in service a favour. I would say it was the other way around cos they are a..ng me a favour ... I work with the team and they tell me what they need.' [Protecting this time is a priority]: 'I say I can't teach on that day because I am in practice, but you have to be bombastic about it ... I cannot have clients and then not turn up for them. They need a regular slot.' (MH lecturer and CPN)

A senior lecturer describes how she would like the team to see her while undertaking this clinical time:

'At best I would like to be seen as a resource, someone to ask advice about their portfolio, or where they can get a reference, or to explain something about the documentation from us [the university]. They have got to see me as being useful and it being a useful relationship, or else it will not work. It does work for me because I have known these people for seven years. They see me as a friend ... they are my friends. Mind, there is a disadvantage of that – I cannot be the person I am now, but I have to be the person I was six years ago ... I would feel very uncomfortable doing my lecturing job if I didn't know what was happening here. I would feel very deskilled. MH contexts change so quickly. I don't know how other lecturers function not knowing what is going on in their specialist area.'
(Senior lecturer and CPN)

Lecturers spending 20% of their time in clinical practice appeared to have many positive benefits:

- 'They have a foot in each camp.'
- Practitioners would use the educators to help them with their course-work or assignments.
- Readings would be suggested or exchanged.
- Programmes would be recommended.
- Enthusiasm for lifelong learning was promoted.
- The gap between theory and practice was bridged.
- Lecturers could use current and real examples of practical issues in their teaching.
- Lecturers could talk about a recent experience while in practice, increasing their 'ward cred' with students – the lecturers were perceived to '*know what they were talking about*'.
- Lecturers regularly brought back feedback and perceptions – about what education and training was needed for the practitioners in the various service areas – to the university.
- Ties were made with service people who could be guest speakers in class.

'Ward cred' could also be coupled with role modelling. The importance of role models both in education and practice was emphasised. At the post-registration level some students believed the programme they were taking was 'good' because:

> *'The tutor is current with clinical practice … he is passionate about what he does and always relates theory to a practical situation which we can all relate to.'* (Forensic MHN)

At the pre-registration level it appeared more important to have good role models in placement than in the classroom:

> *'This is my second week in placement and it is one of my first placements because I am a first-year student. I am 'adult', but I want to go into mental health after this placement. You need a good placement to decide what you want to specialise in. On this placement I have been assessing new patients, I have been in group therapy. I have been on home visits. I have been out with an SW doing a care plan. This area looks more interesting than adult.'* (First-year student nurse, adult branch)

Although for some pre-registration students the practical reality appeared to negate what the students learned about the role in the classroom. Further, their sustained allegiance was to the practice areas. It was education, *'the uni'*, that had it *'wrong'*. The lecturers were teaching idealistic goals and out-of-touch concepts about what happens in practice. This negativity escalated around assignment time ('blame culture'). Practice was what these students wanted to do – *'this is nursing'* – and not *'all this academic stuff'*. The latter was seen as something to get through.

Pre-registration students tended to be more accepting than the post-registration students of the 'gap' between the lecturers and practice professionals regarding practical credibility:

> *'We come back and tell them [the lecturers] what it is like [in practice] and they argue with us.'* (said in a matter-of-fact tone, Second-year pre-registration student)

As with service users, when the students were asked about role models in relation to teamworking negative responses were frequently elicited. They would often talk about people not liking other people, but it appeared to be based often on personal reasons:

> *'Joan [staff nurse] said that Dina [ward manager] is a cow and that I should be nice to her if I wanted a good assessment.'* (Third-year MH student)

At other times it was the profession they represented which created the negative rhetoric: *'SWs are benefits', 'OTs do group work', 'MHNs do depots'*. However, some respondents provided some excellent examples of role modelling in relation to more integrated and rounded views of effective teamworking (Chapter 6). Below is an extended quote that offers a glimpse into how this respondent (a sector manager) encouraged teamworking. We feel examples like this could be a useful way to engage students in learning about teamwork (see Chapter 10).

> *'The philosophy for the unit here is to enable better integration between inpatient and community care. We have seen much more integration and working together. The staff on the wards will call on the community team and vice versa – running groups together. We are two teams working well together as one. We set out to achieve a seamless service and I think we have gone a long way towards it. No service is perfect, but we are definitely along that line. We are also developing a system whereby people can come in for the day and not stay overnight – a partial service for them. So what we have created is a flexible service whereby one individual – patient or client – can take part in any arm of the service – partial, inpatient or community and have minimum disruption for them because they are seeing the same people. But what we found was the more flexibility we had, the harder it was to co-ordinate and control. Because you may have people coming in for a partial on an evening or at weekends – who is responsible for what? Who is going to monitor and review? So the flexibility was great from the patients' point of view but it could be a bit of a headache for co-ordination from our point of view ... We work under one management and one consultant so we are able to work more towards a shared philosophy. For an effective team you have to work hard to get people to want to co-operate and listen and to see each others' point of view. It is not only the disciplines, but the different nursing staff will have a perception of their role depending on the role they are in. You have to get people to talk with each other, to communicate. You have to create the forums for that to happen. Which is part of my role to encourage that communication. We have two team meetings a week in which we have great attendance. We take minutes and they are circulated. We encourage people to say things in open forums and if they do not feel comfortable doing that to do so to their line managers. Recruitment into posts is important so we do look for people with a flexible, co-operative kind of approach. I think the roles are less blurred here than in other teams I have experienced. The SW and the CPN role are respected, for example, but there is a willingness to help each other out. We do things together like the assessment clinic and group work, we will work jointly with our colleagues. We had a team away day and we put all the disciplines in the hat and we had to pull one out of the hat and write down what you perceived the role to be ... On the other side of the paper you had to put down what you perceived to be your own role. That was quite enlightening, it did clarify some of the perceptions people had, it was a way to get to know the team ... To enable us to do it we shut the centre. We do it once a year. Sometimes it might be just for team building ... other times it was because we like had the acute suite opening and we needed to sort out a way of working with that. We do not have a high staff turnover. Cedar Suite has been open over two years and we have just recruited for someone who left on a secondment. People here are willing to be team members.'*

When we asked students where they learned about teamworking, we frequently had responses such as:

> *'Well they [lecturers] sometimes tag it on at the end of a lecture', 'no one comes to talk from other professionals.'* (Second-year pre-registration students)
>
> A: *'It is up to you to identify those needs yourself.'*
>
> Q: *'What do you think you need?'*
>
> A: *'We need more about the role of other professionals. We organise it ourselves. I asked to do this in my last placement and they said, "Don't bother".'* (Second-year pre-registration students)

Following the theme of 'ward cred' and the importance of practical learning, we found our respondents frequently reminisced about *'the good old days'* and the traditional training. Indeed our survey results showed that 50% of the respondents in the service area felt the traditional training was better than the DipHE, while only 21% disagreed.

9.5 Old versus new training

We explored the tension between those individuals who think nursing should return to lower order skills (since the DipHE is *'too academic'*, creates *'theory-practice gaps'* and so on) and those who believe nursing needs to be more *'professional'*, *'higher academic skills'* and based on *'evidence-based, research-based practice'*. It is perhaps alarming that so few service professional respondents felt that current MHN education and training is relevant for practice (42% agreeing, 33% disagreeing). A third-year student on mental health placement commented:

> *'A couple of the tutors come to the wards; I don't know how involved they are. Some of them seem to be in touch. I presumed they spent time on the wards. While they're here, I think they do some work, but not with me. The tutors seem to me to spend time on the wards. I don't think I spend enough time on the wards. It's far too much in college. You do learn 10, 20 times more on the ward. What they tell you doesn't happen on the wards. You learn how to deal with people, which with mental health is the main issue I think. They can't teach you that in college. Until you actually meet people on the wards you don't have any idea whatsoever what it's all about. The week's preparation for this placement wasn't anywhere near enough. They gave us basic outlines of different disorders ... I'm not sure what would have been more helpful other than coming on the ward. You've got to actually be there ...on all different wards and also community.'* (Third-year MH student)

A traditionally-trained MH manager commented:

> *'In terms of training, there's something that's ill equipped about what we're doing with the students. I consider myself to have had a better training, RMN, than what the current group have. I knew that the examination system that was in place, I could not wing it. The modules and the syllabus don't actually equip them for what's going to happen. I've got an absolutely thorough grounding and basis in mental health disorder. You used to have a clinical tutor, and they'd teach you procedures on patients ... The clinical tutor had time to do this because it was their job.'* (MH manager)

Another said, when emphasising the *'shitty'* aspects of the job:

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'Nothing teaches you how to deal with it except dealing with it. I remember as a student the charge nurse told me to go and clean up this guy who was full of mites and he stank! But boy did I build up a good relationship with that person!' (Forensic nurse, ward manager)

'I haven't got the confidence in the students today. I don't think they feel confident to build up relationships with the client ... They don't have the skills you rely on in MH. They have hardly spent any time with the patients. When they go into peoples' homes you see them, they are really frightened.' (CPN)

This reinforces Miller et al.'s (1994) work, which states that 'issues' need to be brought into the classroom from their placement experiences and discussed. However, learning on the job was sometimes ambivalently portrayed. On the one hand there were things which you simply couldn't learn in the classroom, but on the other hand, the past apprenticeship form of learning offered limited, hit-and-miss learning because not all practice was best practice, and it was often repetitive. When looking back on her training, a respondent commented she felt she needed more time in school. It wasn't right that you had the hands-on experience and were on the wards the majority of the time. This respondent was asked about 'lifelong learning':

'Well a lot of people just want to come in and do their job and go home, you know, they do not want to do all this learning. That's not me, that's not me ... but I do question why do we need [to do it], you know. What difference does it make at the end of the day?' (Post-registration degree student)

Others translated 'lifelong learning' into 'undertake courses'.

'We have students with us all the time and you want to feel you can keep up. So you are always looking for the next course ...' (Forensic MHN)

Another was much more positive about how she has embraced the concept of lifelong learning:

'When I was on the degree I was like, have you read this? I was bringing in articles you know ... Before [taking the degree] I didn't feel I had anything to offer to, for example, people with schizophrenia. I do now. I have new skills. I have learned new skills. This is what the degree did for me. This is why I pushed and pushed to do it. This is why I want to do the Masters now.' (Ward sister, acute inpatient service)

When asked about multiprofessional learning being taught at the pre-registration stage, some respondents thought the idea of *'being professional, looking at other areas is excellent'*, but questioned the implementation. Most believed that if this meant having more time in HE, then this was not a good idea. The survey data supported the commonly-held belief that the CFP is too long and many HE institutions were already addressing this issue prior to the new Board guidelines being published (ENB, 1999).

Further, while the educationalists believed that shared learning with students from other professions improves multiprofessional teamworking, there was little evidence that such learning currently takes place. Some of the educational institutions in our case study sample offered programmes in mental health, which were open to other health care professionals – *'but in reality we only get nurses'* (MH lecturer). The survey data also highlighted that the majority of **respondents felt that multiprofessional teamworking was not well addressed in pre-registration** programmes. At the post-registration level only 41% felt current programmes were relevant for teamworking and only 28% felt post-registration programmes successfully promoted good working partnerships.

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9.6 Gaps

Throughout this report we have identified a series of 'gaps' (or incongruencies) within and between policy, practice, education and service users arenas, which were either 'overt' or 'covert'. Further gaps could be created by the movement of education and training from the practice setting into HE. This has taken place over the last 10 years, in an effort to raise the (academic) standard of nursing. This move may have had a great impact on increasing not only the theory-practice gap, but may have created other 'gaps' between individuals in the educational institution and practitioners in the practice setting, perhaps to the detriment of the nursing profession as a whole. For example, our data have hinted at the alienation which is being felt between newly-trained DipHE students and traditionally-trained nurses, with the latter feeling threatened:

> *'I'm scared of the students today, they read so many books.'* (Sector manager)

In the current climate, nurses are continually pressured to base their practice on evidence. Perhaps evidence-based practice and the relocation of nursing in HE are related. The latter is an institutional bid for status, aimed at closing the status gap between nurse and doctors. The former is an epistemological bid for status, an attempt to attain the same sort of 'scientific' basis for their professionalism as they imagine that doctors already have.

The supernumerary status of student nurses means they are no longer counted as part of the workforce – a further irritation for busy practitioners providing the taught aspect to students on placement. This may lead to the worrying observation that by not adequately preparing students for what mental health nursing is like, *'people drop out when they hit the wards as qualified staff... the reality never meets the expectations'* (Manager, acute). In addition, it is claimed that the new breed of nurses are more autonomous and 'knowledgeable doers' – thus creating a gap between staff who qualified many years ago who feel threatened because they lack the paper qualifications. Further, it was felt that current students were taught more about managing than providing care, which represents a big shift away from the traditional skills and training of nurses – with some nurses believing that *'nobody wants to be a care-giver anymore'*. This shift, as we noted earlier, was blamed on senior educators and nurse leaders within the Board and UKCC, who it was felt had made the mistake of:

> *'[Assuming] that "professional identity" meant academic qualifications ... rather than understanding responsibilities. [Unfortunately when you go for a job the interviewers] look more at the qualifications and the courses you have taken than your experience.'* (Forensic staff nurse)

Although some would argue that the academic standard of nursing has been raised, there still remains a prominent 'gap' between the professions. It is only nursing which, in the UK, remains a non-graduate profession among medics, SWs, OTs and so on. This is a significant gap when considering multiprofessional teamworking:

> *'How can we work in partnership when the partners are not equal? The problem is the different levels. SW and OT is at degree level and nursing is not ... We need to be in line with other professionals and then we can start on an equal footing and move on from there.'* (Lecturer and CPN)

As new gaps have emerged and some existing ones widened, mechanisms and strategies have developed as a way to smooth the developing turbulence, such as:

- reflective practice
- evidence-based practice
- competency-based education
- multiprofessional teamworking.

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Research-based knowledge, for example, seeks to 'smooth over' these gaps, or even remove them altogether, by providing resolutions in the form of new rhetoric, procedures, linking mechanisms, as well as ways of translating knowledge into use and theory into practice. On the other hand, however, there are the teachers who say it is their job to make a gap between theory and practice because practice is quite pathological in places and, in fact, you do not want people to accept this reality as what nursing ought to be about. For example, the role of the nurse in the curriculum is expressed in terms of negotiation and collaboration and collective endeavour.

The sociology of that work context would indicate that it is full of conflict, compromise, difficulty and stress. Thus we argue there is a contrast between a routine utopianism (fantasy?) in the writing of the curriculum documents and an unwillingness to acknowledge in the document the much more 'messy' nature of the reality of the workplace – partly because 'it shouldn't be like that'. Indeed, education always has a 'should' written in. It is possible to understand why people would want to write it in – to idealise the curriculum because they want practice to catch up on the educational prescription of what mental health nursing 'ought' to be. We question whether the experience of students spending extended periods of time on placement (immersion in reality) engenders an experiential taxonomy/stage theory of how they adjust to reality after leaving their (idealistic? utopian? theoretical? protected?) classroom setting. Perhaps a best-case scenario is deliberately constructed in the knowledge that it probably won't be realised and it might not even be terribly visible in many of the placements. Whether this is regarded as utopian, or appropriate, or as a professional nostalgia for better times, is open for debate.

9.7 Credentialism and 'career creep'

Our data seemed to show a trend for some qualified staff to undertake post-registration programmes (in particular a degree) not to creep up the career ladder in nursing, but to creep out of the door and into another profession.

> Q: *'What are you going to do with all this new knowledge?'*
> (talking with the post-registration student on a BSc Community Health Programme)
>
> A: *'Ahhhhh! take my career off from all this education! Hopefully I will never have to come back! [laughs]'*
>
> A: *[Another responded] 'I am doing it [getting a degree] to get out of nursing ... the NHS are paying for it, but I have been looking into joining the police once I have my degree. They [the police] have accelerated learning and you get rewarded for the knowledge that you've got. But here [in nursing] I will be going back to my same job, same grade, no incentives. Why stay in a profession if there is no movement, when you can go elsewhere and be more appreciated?'* (Two CPNs, post-registration degree students)

Similarly at the pre-registration level students saw the diploma as a cheap way (because of the bursary system) to get qualifications, which could be used as a stepping stone to go into another career *'the ambitious ones are doing courses to get out of nursing'*.

Some respondents also expressed the concern that the 'academic' nature of nurse education and training (for example, research methods) was discouraging some individuals who may make very 'caring' nurses, or bar others if they fail this part of the programme. This begs the question as to whom the profession is attracting – a question of some importance given the current national shortages of nurses. However, the new government initiative of consultant nurse posts may encourage nurses to continue their careers in nursing.

9.8 Discussion of the themes from the case studies

The examination of our case studies revealed many different 'layerings' which, we argue, have merged to become a shared and powerful view of what mental health care encapsulates. This illustrates the location of users, MHNs and multiprofessional teamworking and how policy and educational approaches influence and are influenced by the grounded practice of mental health care professionals. There was often great diversity and richness in this picture, perhaps easier for us to see as we deliberately attempted to view the familiar (for the mental health professional) as being unfamiliar and strange. This diversity was reflected in the range of care settings in which mental health nursing takes place, the way in which MHNs were prepared for practice and, to a lesser extent, how service users experienced their relationships with MHNs. The findings reflected this diversity, and indeed, the complex and sometimes contradictory nature of respondents' experience.

Our starting point in Chapter 6 was to revisit the experiences of the user. Despite sustained calls for greater user involvement at all levels of service planning, provision and evaluation, little evidence was found that illustrated anything more than a tokenistic outcome. Many of the users had found contact with mental health services to be disabling rather than enabling. Many users experienced a relationship with MHNs that was constructed around intervention rather than empowerment. Clearly there were many individuals who enjoyed more enabling relationships with individual MHNs, and these accounts often reflected the personal nature of the relationship as in 'knowing someone' rather than the more generalised relationships with MHNs. So John or Jill became a 'good' nurse whereas MHNs were often reported as being 'bad'. This finding brought into sharp relief the 'being' and 'doing' aspects of MHNs.

We argue that the value of the nurse-patient relationship is, perhaps, tied in with its 'taken-for-grantedness', reflected in the seeming lack of emphasis upon this within policy rhetoric. Emphasis upon collaborative working could, perhaps, be said to overshadow nursing ethics of care, phenomenological presence and ordinary humanness, making these somehow marginal to effective, therapeutic, evidence-based interventions. In the experience of many of our respondents, service users remained on the periphery of policy and practice formulation, implementation and realisation. Many individual users expressed a willingness to participate in the training of MHNs. Not responding to this critical mass of experience would appear short-sighted and indefensible, from educational, professional and practice perspectives, and renders some of the policy objectives of the NSF rhetorical if not redundant. Such an apparent inability to more effectively embrace the resources available in the mental health care ecosystem was evident at the national, organisational and individual levels of policy formulation, implementation and realisation.

Mental health policy, in the form of the NSF (DoH, 1999a) and *Modernising Mental Health Care* (DoH, 1998), while espousing local autonomy, continues to be regulated through centralised accountability. This created a number of paradoxes in the experience of many of the respondents. For example, the current system of compartmentalised training for professional groups does not appear to be able to support shared learning, or holistic approaches to care, yet service performance is measured against the outcomes of multiprofessional teamworking. Many of the teams we worked with across the case study sites were made up of individuals who had been told to become members of a team – the notion of teamworking was imposed. This inevitably results in an environment where spontaneity and innovation are only likely to emerge where a charismatic leader is present, and then often only for as long as they are a member of the team.

We argue that the MHN's role, both as a uniprofessional and a multiprofessional team member, remains in 'crisis' and under pressure. We seldom get order and stability in society. Education needs to reflect this situation. Further, when groups of professionals are working within increasingly tight financial constraints and increased workloads, multiprofessional teamworking can scarcely be a reality (Heath, 1998). Thus, teaching for and

about multiprofessional teamworking may appear to be a sound concept for developing a symbiotic relationship between professionals but, in fact, may be utopian. Unless recognised as such, individuals may feel inadequate if they are not engaging in teamwork effectively. Scapegoating and blame usually ensue if individuals feel threatened, often reinforcing gaps between professionals.

More recently, the nursing profession, in striving to establish itself as an academic profession, has turned to evidence-based and research-based practice to provide the credibility it perceives it requires (DoH, 1997a). Evidence-based practice is still predominantly based on the scientific paradigm of objectivity and measurement in order to be generalisable. Unfortunately, the nursing knowledge produced, as a result of this type of evidence-based research and practice, again, often does not match the 'messy' realities of the practice setting. At best, the theory can help to provide a macro explanation or a prediction of what is happening, or may happen, in practice. It may provide little, however, to the student nurse who is faced with (micro or individual) practical situations that do not match the context in which the theory was generated.

Likewise, health care organisations focus on the macro (or national) objectives without connecting them with the powerful pressures at the micro level, where individuals constantly traverse independent and interdependent relationships. The result can be a multi-agency environment where polarised positions are defended in the quest for the maintenance of stability and equilibrium. Polarised views are first learnt and then reinforced through powerful processes of professional socialisation. These continuing processes are likely to perpetuate gaps between professionals. We argue that, in the experience of our respondents, such gaps lead to an outcome where the prevailing practice and educational culture is based upon control, conflict and often contradictory ideals. Can such an environment effectively promote teamworking?

10.1 Introduction

Can teamworking be 'taught', or is it better 'caught'? Concepts such as 'collaboration', 'partnership' and 'teamworking' are difficult to realise and to learn, since teamwork is situated in a turbulent context. Where and how should it be taught? Teaching the 'ideal' of multiprofessional teamworking might only foster cynicism, as individuals fail to reach the utopian dream, creating 'gaps' between the real and the ideal. Thus, teamworking needs to be understood in contextual terms. We recommend that the politics (e.g. blame culture, competition, differing ideologies) within and between professions and professionals are inspected. Further, we need to equip individuals with a way to 'read' and deconstruct group interactions which does not reduce them to formulae for 'effective' or 'ineffective' teamworking, but is dynamic, multidimensional – even contradictory and confusing.

We suggest that case studies can be a way to offer students (and others) a research-based 'working theory' with which to analyse situations. A theory of, for and about practice. To this end, we have developed a series of educational vignettes. Here we provide an example of how an educational vignette could be used as a learning tool; three further vignettes can be obtained from the authors. The data for these vignettes are taken directly from the fieldwork during the case study Aspect. They are written in the first person and provide personal accounts, or 'readings', by us of our experience and interpretation of individual's and group's working patterns and relationships. Challenging these interpretations is to be welcomed. Indeed, diversity, as opposed to universal prescription, is advocated in relation to acknowledging the dynamics of contemporary mental health settings. The purpose of the vignette is stated at the beginning. The vignette itself is followed by a series of 'learning points' which aim to engage the individual in a critical identification of the complexities and dilemmas of policy; 'models' of practice and patterns of multiprofessional working. In doing so, students (and others) build their own evidence-base, which is not built on the 'ideal' (optimal), but which is located in the real, everyday 'habitus' of individuals in mental health settings.

10.2 Example of an educational vignette

10.2.1 The CMHT meeting

The purpose of this educational vignette is to:

- portray some of the sorts of issues that such meetings address and what it is like to be there as an observer
- bring out some of the teamwork issues that emerge during and after the meeting
- look at the business of 'reading' the event, to help student nurses observe critically as part of their development of a research-based approach to professionalism.

Meeting the meeting

It is a hot day. I sit by the window. The CMHT forms a rather cramped circle, with the consultant directly opposite me, seated beside a small table. He seems to be central to the group although C (an 'I' grade nurse) is the team manager. Somebody explains to me that C is the team leader *'and so she should sit alongside, technically, Dr D, really'*. I wonder what the words *'technically'* and *'really'* imply. What does *'alongside'* leadership look like?

In the group there are five community nurses, an SW, a housing support worker from a charity, as well as a housing manager and the team secretary. They all seem to know each other pretty well – there's a lot of joking, greeting and catching up before the meeting begins. Apparently, there are fewer present than usual. One of the CMHNs chairs the meeting, rather diffidently, with the air of a man asked at the last minute.

The first case is Mr E. A doctor's letter is read out. Several in the group recognise the client. Apparently, he *'hallucinates'*. One team member suggests that G (a CMHN) might see him, but H points out that he himself had previously worked with the client over a period of seven years. The team manager also recognises the case and comments that he has an *'odd presentation'*. Another nurse adds that she knows that he has been seen weekly, and that she doesn't understand the letter. It turns out that the client has been connected to various members of the team over a period of time. And he has a *'habit of sabotaging things'*. His file is consulted again and a note from Dr O is read out. The client had been discharged at that point, and seems to have moved on to a new doctor. Had there been any change in his behaviour? No one thought so and the housing support worker declares himself *'a bit mystified really'*. One of the group wonders, *'Is it a new story for a new GP?'* It is agreed that they should check what's going on via an outpatient appointment.

The second case is a woman with four children who themselves have psychological problems. She suffers from panic attacks and phobic problems. Previously she had been referred to a women's group. One of the group reports that in the past she had not proved easy to help. She wants a re-referral. The GP has asked if there is more that they can do to help. The team leader suggests that she suffers from a 'selective' agoraphobia, and that her background as a member of a very strict religious sect may be relevant. There is a silence and someone adds, *'she's had so much'*. Another comments that she had rejected help from the Mental Health Support Group. She has a *'huge dependency'* on them, and they have to try to break that cycle. Perhaps they should offer 'self help' as a first step in that process. The Chair nods and places the file on the secretary's desk.

The third case is a woman with an eating phobia, which affects her employment and career prospects. *'Ah'*, says one of the CMHNs, *'I saw her recently. She's remarried'*. The new husband has eating disorders. What should they do? The consultant picks up on the news of the husband. *'So what's her fear?'* another asks. The SW adds that *'she shakes, and looks bad'*. They discuss the high caseloads and the difficulty of fitting her in. It is noted that an OT will start with her in October, so maybe they could phone her and tell her she is on a waiting list. The consultant says *'you've started, got to follow up and not leave her hanging'*. They agree there has to be an interview. A final suggestion is made by one of the CMHNs: maybe they should send her some literature on anxiety in order to *'prime her for the interview'*.

The fourth case is a client who has been transferred to a nursing home. Both the consultant and the team leader comment that that seems too much, since three months ago he was still living at home. The consultant wants a *'lively, more stimulating environment'*. The starting point, says the SW, will have to be a social needs assessment. The problem is that it's a *'classic resource-based'* dilemma. He's not entitled. The housing support worker wonders if *'Dick'* – several seem to know him – wouldn't take advantage in the nursing home. He'd love to *'laze about all day'*. There is animated discussion of the *'excessive'* nature of the placing in the nursing home, and one CMHN concludes that *'knowing Dick Wright as I do'* he'll cause problems in the place. The SW agrees to take the matter in hand.

The fifth case concerns a client who has moved out of sheltered accommodation. He came to see the SW. She adds that *'he has strange ideas'*, believing that his illness is caused by light passing through Victorian coloured glass windows. He had sounded a bit psychotic when she last saw him, but his mother had got him a flat and he was wondering about housing benefit eligibility since his mother would be his landlady. They think that he is eligible, but the SW undertakes to find out. The housing support worker joins in the discussion of the

client, who is felt to be getting worse. There is no agreement on this deterioration, one CMHN feeling that *'he's OK'*. Another joins in, recognising the name as someone who had previously been in the Men's Group.

The sixth case involves a man who is reported to be very ill, *'very disturbed'*. He had been admitted to hospital suffering from a delusion about spotter planes. The purpose had been to give him a break, but his medicine wasn't working, the nurses couldn't cope so it had to be a Section 3. The SW adds that she knows the case and that *'he is a very unhappy man'*. *'He thought the world was a concentration camp'*, with police and spotter planes in his pursuit. It was doubtful if the mother really understood because she is learning disabled. In fact she is doubtfully competent to agree to sectioning. The SW agrees to look into the case, and the team leader asks if it will be necessary to go to court. The SW doesn't know and will *'need to do my homework on that'*. They'd have to bear in mind the Mental Health Commission, says the consultant.

The cases – 13 in all – went on all morning. To this observer, as indeed probably to any student nurse observer, the cases were arresting stories in themselves, and the group seemed to pass around each story with different individuals either adding to the factual content of the current situation, offering an aspect of its history, making an evaluation of the client's condition and case, or suggesting a way forward. Different individuals undertook to take action on behalf of the team and to report back on what happened. The impression was of an relatively informal shared learning process, dominated by the nurses, contributed to by the SW and housing support worker, and commented on by the consultant. He tended to have the last word, but in terms of summary rather than judgement.

Note that this is *not* a representative account. The cases were not necessarily typical, and it is possible that the presence of an observer changed the nature of the meeting (some thought so and some thought not). But what issues did the meeting raise for a consideration of teamworking?

10.2.2 The meeting and missing of minds

In order to get at some of the hidden agendas inevitable to such meetings, I interviewed a number of the participants after the meeting. They represented each of the different groups present. A number of surprises resulted.

Differing professional talk

> SWs: I'm really *'not happy'* about these meetings. Sometimes people are not *'being respectful of the issues raised'*. We need *'ground rules'* for how people talk in the group. Sometimes there are jokes about people's sexuality, an unprofessional *'flippancy'*. As SWs, we're very interested in *'anti-discriminatory practice'* and a more *'business-like approach'* to the cases. With the nurses it's more like *'gossiping, which again in a social work culture is not how we talk about our clients'*.
>
> Nurses: Mental health nursing is a stressful and difficult job, so it promotes a *'very black sense of humour'*. MHNs are *'quite hard, caustic people'*, *'basic'*. *'We're very jokey about things, fairly light hearted. I think that's quite a good way of getting through the day.'* SWs are a lot less *'caustic'*.

So, two very discrepant 'talk cultures' underlay the surface agreements of the team meeting. Yet I had seen nothing of this underlying tension. One SW felt that the nurses had behaved better because an observer had been present. They also tended to assume that I was on their side (as an 'academic'). The nurses I spoke to seemed to believe that their approach was more human, less formal, and yet no less caring. They had been happy to point out to me that MHNs often have a *'black'* sense of humour.

The value of face to face

One of the more peripheral of the CMHNs put it this way: *'It's a case of, if I wasn't here ... people forget about you or your possible contribution'*. It helps to *'know faces'*, and to hear them talking about their discipline's contribution, allowing a *'greater understanding of how other disciplines work and what models they use'*. *'You need to have a strong awareness of what other people do.'* There was general agreement about that.

It became clear from the interviews that followed the meeting that there had not been one meeting, but three – before, during and after. People shared a lot of news of clients and other professional developments before and after the formal meeting. One of the SWs concluded that *'the good work actually happens outside the meeting'*, while the CMHT manager noted that the exchanges after such meetings were important, the chats outside, cups of tea, smoking – *'the informality is just as important as the formality'*. They also altered the nature of subsequent telephone and written communications, allowing an implicit appeal to relationships rather than job functions. Teamwork developed *'goodwill banks'*.

In terms of 'face', people learned through these groups to read some of 'blurred' distinctions between these roles, the *'skew-whiff boundaries'* that made professional faces less distinct. They also learned the notion of 'face' as a status marker. The group enacted a hierarchy, which was variously asserted and denied. It was all *'fairly equal really'* (team leader). It was dominated by the doctor:

> *'It's this power thing, I think. It's very hard when you've got a consultant sitting there to sort of try and get them back on track talking about things other than medication and stuff.'*

One team member found it an isolating experience, feeling herself to be only a *'paraprofessional'* among those who felt themselves to be real professionals. It was the risk of losing face amongst a dominant bunch of CMHNs who used the meeting to *'exchange information amongst themselves'*. We could conclude, then, that there wasn't one meeting going on, nor three, but lots of meetings – most of them *'hidden'*. And face, loss of face, assertion and deference all accompanied the rhetoric of needing 'parity' or even claiming that it had been achieved.

Teams

You can feel it getting complicated. To work well in a multiprofessional team you need to get to know the other discipline. That's rational. You need to get to know the other person. That's personal. Then you need to understand the politics under these surfaces, the different ways of talking different professions have, and the conflicts between their underlying models of practice – medical, social, therapeutic, and so on. Conflicts about professional etiquette, talking *'properly'* about your clients, either joking or not joking about the situation. Once you've got that, you've also got to read *'face'* as a question of status as well as immediacy. There are people in there feeling disempowered by the group's discourse as well as people happy with the talk between *'equal professionals'*. There's a lot more going on than meets the eye.

And there's a lot more to be said:

> *'As far as the other disciplines [are concerned], there is a feeling they come along to the meeting and it is a nurse-led thing, it is very medical-led, and that we use it to deal with nursing and medical-type issues, and they have to sit and wait till the end to have their say.'* (MHN)

> *'We do work together as a team but we don't work together. The hidden agenda is that we don't really work together ... we are all protecting our own profession as well, I suspect.'* (SW)

Yet the team manager summed it up very differently:

'I think they are quite a cohesive group, I think that they are very ... they know each other, they have no difficulties in communicating.'

So it looks like how team members see their professional role has a lot to do with how they behave in the team. For example, an MHN (by training) who was involved in both drug and mental health treatment, working for a charity, saw herself as dislocated from other professional groups who were tempted to translate all of the problem into a drug one. Her role in *'dual diagnosis'* made her something of a stranger in that sense. It also made her feel that she was no longer *'really a nurse'* and she was happy about that. Her job was facilitative, negotiating between various providers of services and the client for whom she *'advocated'* – *'the client is the centre'*. And the team was necessary for bringing about multifaceted care. That sounds clear and admirable. But when she went on to define that *'centredness'* she said, *'that's the needs of the clients balanced against the demands from other professionals and the understandings of other professionals, how that's all going to work together'*. *'Needs'* didn't stand alone, then. They had to be balanced with other things. As she said, it's *'complex'*.

The team manager thought the problems faced by the group were mainly the absence of a shared suitable base, but also the overload caused by the expansion of primary care in mental health.

'It's much more fragmented now, because you've got all these GPs and the fragmentation, I should think, comes from the sheer pressure of the demand for primary health. And if you actually took that out of the problem and had case loads like 34, 35, 40 people with serious mental illness then have time to become involved with the families, with the social networks of what's going on for the individuals – and actually become much more involved in their treatment. The other point of course, which adds to the fragmentation, I think, is that many of our patients' presentations are complicated by the society of today. Drug misuse, alcohol misuse – much more prevalent than it was 17 years ago.'

Apart from structural problems, and geographical distances, it was easy to define what people took to be the characteristics of a good team. Here's a fairly typical list of ideal characteristics from one nurse:

- *'want to work with us'*
- *'self-motivated themselves'*
- *'be able to work flexibly in sometimes chaotic situations'*
- *'be able to prioritise their workload'*
- *'sense of humour'*
- *'tolerant of skew-whiff boundaries'*.

It was generally agreed that the main problem was what they *didn't* have – a common base, *'one office space'*, not that hot cramped little room. People also needed to be empowered to speak, although whether people were empowered, silenced or marginalised was controversial. People needed both to keep their professional identity, and accept overlaps and diffusion. But there was little agreement on what that identity was, nor on how it could be retained, nor on whether it should be kept. Several nurses felt that the generic mental health worker would be a step forward and would prevent the situation illustrated in the observational account – where *'two or three people added their bit'* instead of one person knowing the whole story.

Others felt that there had to be structural changes as well, before a *'good'* team became a real possibility. At the moment the hidden agenda was that they all had separate systems, budgets and accountability. This multiplied both the paperwork and the defensiveness:

'We're still client oriented, they're resource oriented.' (MHN)

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The different pressures meant that under the co-operative teamwork surfaces, people were fending off intrusions into their territory, resenting the *'retreat'*, or resenting the unwillingness of anyone except the nurse to take on the keyworker role.

Nurse roles

You can't understand good teamworking without understanding the tensions between the different professional identities and roles. One acute nurse listed the distinctiveness: *'I do depots, the OT does physical bodies, the SW does the housing, and the doctor does prescriptions'*. The rest, she said, is blurred. She was happy with that blurring, but in general the nurse role seemed to be experienced more often as a put-upon worker. MHNs were low status – the *'Cinderellas of general nursing'*. They were the ones left holding the can, whether that meant signing for the CPA because nobody else would do it, or catering for the basic needs of the patient or client (14 hours a day, seven days a week, bottom half as well as top half). They *'did not have a remit for not seeing somebody'* whereas other occupational groups could accept or reject referrals. Our *'remit is to soak everything up and that's causing a huge problem for us because we're not resourced to pick everything up'*. Nurses collected the *'fall-out'*, the *'left-overs'*. They were always the *'bottom-line'*, and the phrase *'jack of all trades and master of none'* was seldom far away.

Yet nurses also generally spoke warmly of their role. Most felt that it was about relationships, communicating, negotiating with their clients. They said things like:

> *'Nursing to me is actually communicating with clients, enabling them to use the skills they've got.'*
>
> *'Their real skill is their ability to relate to people who have difficulty relating to the rest of the world.'*

The team met to piece together clients' stories, both as histories and as diagnoses of needs. This notion of *'broken stories'* was also important for other nurses associated with this team – as *'extended members'*. In one way at least they regretted the passing of longer-term care. Pressures on bed turnover meant that, in terms of relationships, *'nurses do little chunks now'*.

> *'The staff on the acute wards, or whoever, think, yes, this would be ideal. They would put a referral in and then one of the consultants would say, "What have you done here, why have you got this referral to the hostels? I don't want them to go to the hostels, I want them straight out." It is complex really. Whose best interests are at heart, the consultants or the clients?'* (MHN)

These pressures resulted in, it was said, a *'revolving door'* approach to admissions and discharges. The loss of relationship was perceived as *'reductionist'*, *'we are perhaps an assessment and crisis service rather than a treatment service'*. As a result, the *'holistic'* ambitions of the individual team member and the team itself were difficult to achieve. The result was a *'very short-term model of care'*, and sometimes a retreat to *'paperwork'*:

> *'I feel the pressure is on whether your paperwork is up to date and whether you have crossed the Ts and dotted the Is, rather than whether your clients are getting the proper care.'* (MHN acute)

So what we seem to have here is a role in doubt, and sometimes in crisis. Round that, a context of uncertain negotiations with other professions in the MDT. Overlaying that, a service seen to be resourced in ways that made it difficult to achieve its goal, expressed to us by a senior management figure as the MHN as *'a much more rounded bio-psycho-social interventionist type of professional'*, within a *'managed'* rather than an *'autonomous'* profession, developing through education-led change and facilitation rather than control mechanisms.

Stage 1 in understanding was observation. Necessary, but by itself, inadequate. There is much that any observer may misunderstand. There is much that simply isn't available on the surface of the encounter. Our subsequent interviews developed a second layer of interpretation – Stage 2 – looking at the different perspectives and beginning to work out why they differed so much. What were the pressures from interdisciplinary difference and rivalry? What were the resource and management pressures that made co-operative working difficult? What were the prescriptions for improving things, and how promising did they seem to be?

We acknowledged the need to look for the *'hidden agendas'* of teamwork. We needed to read what people said very carefully and closely. When a team member said that the team both worked and didn't work, we could now offer an explanation of what they meant – that teams work at different levels and that co-operation and competition often co-exist. When someone said that they were client-centred and others were resource-centred, we get a sense of the underlying conflicts, as participants perceive them. And slightly mysterious remarks such as the one we cited earlier about the status of the team leader: *'... she should sit alongside, technically, Dr D, really ...'* begin to make a little more sense, as subtle markers of status and hierarchy within which even team leaders, if nurses, can only ever be *'alongside'* doctors.

Stage 3 is an attempt to develop and apply theory that helps to explain nurses' discourse with professional colleagues in such encounters. It was noticeable, both within the group and in individual interviews, that nurses and others had two rather distinct sorts of concerns.

One list included:

- bed occupancy rates
- patient turnover
- conformity to CPA administrative procedures
- the *'broken stories'* of patient histories
- crisis management
- risk assessment.

These were usually talked about as being distinct from, or somewhat in conflict with, another set of concerns and values:

- client-centred practice
- negotiation
- relationships
- patient needs
- equality
- practical help for the patient
- how the role used to be
- time for all of the above.

These tensions were encountered both in talk about an individual's own work, and in teamwork discussions. As far as the people involved in this case study were concerned, the *'balance'* between these competing concerns was wrong, and so stress levels and job dissatisfaction were felt to be high. These notions are relevant to the way MHNs seem to construct their identity and sense of commitment, and are relevant, therefore, to understanding the multiprofessional encounters that they have. From here, it is a short step to developing a *theory* of MHNs' professional identity.

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The pressures of the first list reflect an 'economy of performance' – targets, deadlines, turnovers. The second list refers to a more holistic, relationship-based version of the role which might be referred to as an 'ecology of practice'. We might therefore begin to think of the 'crisis' in mental health nursing as expressed in the tensions and contradictions between these two registers.

Of course, there are alternative readings to this. You might say that the nurses are right – listen to them and give them more discretion and time. Or you could say that such data merely illustrate the *'culture of blame'* – this is a theory of professionalism built on the sands and straw of nurses' occupational tendency to moan.

10.2.3 Learning points

How close to your experience of multiprofessional team meetings was the meeting presented here? What factors can you identify that might be the reasons for this?

The meeting was an 'everyday experience' for the professionals taking part – how can you make the familiar unfamiliar in trying to understand what significance each individual attached to the role they adopted during and after the meeting?

Consider what 'hidden agendas' were revealed in the respondent's accounts. The multiprofessional meeting seems to bring these different orientations into interesting overlaps and conflicts. The performance of these differences is a largely hidden one, how might you reveal it?

What impact on teamworking and professional motivation might the *'broken stories'* experience have on individual practitioners? How might this be overcome in practice?

What did you learn about:

- multiprofessional teamworking?
- the role of the MHN in the team?

10.3 Summary

This vignette is presented as an example of a learning opportunity for mental health students (and others). We believe this is a step towards gaining an understanding of the complexities involved in today's mental health care, which might allow a more creative view of how to respond to teamworking more effectively. It is also a way of bringing teamworking to life, rather than as a detached commentary that students are unable to connect to the realities of practice. The students can experience teamworking 'vicariously' through these vignettes. In so doing, they form their own possibilities for their 'uniprofessional' and 'multiprofessional' role by exploring various zones of comfort and challenge.

11.1 Introduction

Our brief was to evaluate the effectiveness of the MHN in multiprofessional multi-agency contexts. In our original research proposal we outlined how we would examine a *'variety of job performances'* (p. 1) in different contexts. Then we would look at educational practices, and their congruency – via philosophy, policy and procedure – to service needs. Our interest was in the *'match or mismatch'* (p. 2) between education and professional practice, and we intended to reach *'overall judgements of educational worth and the identification of the implications for educational provision and evidence-based professional knowledge'* (p. 2). Such an interest in 'evidence-based' professionalism meant that we would borrow or devise models of professional practice that would capture, as much as possible, the realities of doing the job of the MHN. Our initial hypothesis was that Jamous and Peloille's (1970) notions of *'indetermination'* and *'rationality'* would help us understand dispositions of power and expertise in professional practice, especially in teamwork and multiprofessional contexts. While Jamous and Peloille's work provided a useful starting point, we eventually developed our own theory of contemporary professional practice, within which to locate our understanding of multiprofessional and teamworking issues. Such a theory is not a matter of irrelevant abstraction; prescriptions for roles make explicit and implicit assumptions about values, principles and, in particular, what would count as 'effective' performance or 'excellent' practice. For example, the current 'competency' model is as much a theory of practice as it is a prescription for practice.

The nature of this 'new professionalism', embedded as it is in national specifications of competence, deserves some further comment. We argue that it is a form of restriction involving a managed (rather than self-managed) and externally accountable specification of the role of the profession. It is also a further rationalisation of the professional role, attempting to establish evidence-based protocols for effective practice, and specifying a 'universal practitioner'. It is tempting to counter this new model with the rhetoric of the 'reflective practitioner', as indeed do many of the curricula we examined. However, we assert that it is worth considering the criticisms of Jonathan (1993) in relation to reflection. She argues that reflection is not enough when the current *'fragmentation of value'* results in the *'new pluralism of the self'* (Jonathan, 1993: 173). Our data indicate that this pluralism of the self includes the uncertain and conflicting 'identity' of the MHN and hence the often problematic engagement of the MHN in multiprofessional work. Jonathan argues that reflection simply deepens the crisis of the self in such situations – that is *'the true existential problem of modernity'* (1993: 174). We conclude, therefore, that reflection on role, on individual performance, on specific outcomes, is never enough. The professional must engage also in a critical identification of structural as well as individual problems, as well as a critique of the ways in which competencies and audits oversimplify the world of the professional while seeming only to make it transparent and accountable.

We argue that our model is grounded in empirical research into the nature of professional practice and training, and that it has some explanatory power as we come to try to understand the complexities of role, identity and multiprofessional practice in contemporary mental health settings.

11.2 Theorising contemporary professional practice

Here we explore the emergent concepts and theories of professionalism. We also examine the dynamics of professional change, as such changes tell us something about the dilemmas of identity and role that are entwined in multiprofessional work. Our final task is to

understand the nature of policy dynamics in contemporary professional settings, the implications for 'models' of practice, and patterns of multiprofessional working.

11.2.1 The (in)congruence of espoused theory and theory in use

In considering the possibility of evidence-based professional practice, it is important to begin by looking at the ways in which professionals actually go about the business of justifying their practices. We assert that it is necessary to think about evidence-based practice in contextual terms. The model that is usually offered (Booth, 1996; Hargreaves, 1997; Sackett et al., 1997) tends to be over-rational, decisionistic and individualistic: *'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients'* (Sackett et al., 1997: 2). Nevertheless, such reductionist views have an attractive clarity and certainty:

- convert these information needs into answerable questions
- track down, with maximum efficiency, the best evidence with which to answer them
- critically appraise that evidence for its validity
- apply the results of this appraisal in our clinical practice
- evaluate our performance (1997: 3).

Sackett et al. (1997) encapsulate evidence-based practice within an ideology of *'lifelong, self-directed learning'* (1997: 2). A more nuanced version of evidence-based professional practice is offered by Humphris and Littlejohns (1995), as more of an *'interface between the world of science and the uncertain art inherent in the process of providing health care through clinical judgement'* (1995: 218). Such assertions locate evidence-based professional practice in a more dynamic context. A tension is acknowledged between the attempts of the individual (or profession) to 'optimise' their fitness, or utility for purpose, and the recognition that finding such an optimum is illusive – the most that is possible is for the *individual* to change and improve, relative to what other individuals and professionals are doing.

What is clear from our data is that it is philosophical and practical naivety to assume that professionals can often ask the question: In this circumstance what should I do now and on what grounds? They lack the time to do so, even if they have the inclination. Tradition, custom, time, compromise and uncertainty are more likely to prevail. Nevertheless, it is clear that the professionals we spoke to locate their practice on a countervailing continuum of espoused theory and theory in use (Argyris and Schön, 1978), that is to say, they made some sort of non-arbitrary justificatory appeal. The actions professionals take are not accidental. It has been argued that individuals design the action they take, their action is consistent with a theory and they are therefore responsible for the design. However, our data indicate that although individuals design the action, they were often unaware of the design and of its difference from their espoused design. In the case of some teams, for example, our data revealed ineffective teamworking while the team managers perceived effective teamworking. Thus espoused theory can be said to represent the worldview and values individuals believe their behaviour is based upon, whereas theory in use is the worldview and values implied by their behaviour or the knowledge maps they use to take action.

We conclude that a self-understanding of the mismatches between espoused theory and theory in use could add both an inductive and a deductive dimension, as MHNs draw on personal experience, ward wisdom, or medical knowledge in their practice. Thus, the particular paradigm drawn upon in justification might be, at one level of awareness, coercive, regulatory, or generalisable, or at the level of unawareness, inductive, permissive, and idiosyncratic. The status of the notion is also different in that it is not prescriptive. The balance of personal (professional) congruence between espoused theory and theory in use could be almost anything – it assumes only that professional decisions of whatever kind are based on some sort of rationale/assumption/appeal to experience/tradition/desire. All that is excluded is the wholly arbitrary. We conclude that 'evidence-based' or 'research-based' practice needs to be understood as an

orientating question rather than a description. We can now clarify two research questions: How do professionals individually and collectively justify their practical decisions, including those that involve desire, compromise, coercion, boredom, stress and cynicism? What do these processes tell us about the potential of 'evidence-based' practice as a model for professional activity?

On the basis of our evidence we argue that these justificatory appeals are hardly ever entirely based on reason, but involve a whole gamut of other things, some of which accumulate as affective/cognitive agglomerates (c.f. Bourdieu's sociological notion of the *'habitus'*), as customary ways of thinking, deciding, acting, evaluating, and feeling. The notion of tradition points to the need to think of 'evidence-based practice' also as a question of biographical, organisational, and cultural reference. Things go before 'evidence-based' decisions in ways that get neglected, as well as alongside and after. And not everything, of course, can be expressed in 'evidence-based' terms, especially in the 'person-centred' definitions of the role.

This notion of plural influences incapable of being purified into a simple, unitary working 'model' of practice is accompanied in the data by the sense of conflicting regimes both in the education and practice contexts. We have already shown how different curricula 'personated' individual nurses, and their collective work with others. A major tension seems to be between an audit/accountability drive and discrepant notions of what ought to constitute professional responsibility. However, it was noticeable that espoused theory and theory in use justifications connected directly with teamwork were often resource-driven, and left MHNs uncertain about status, role and esteem. They tended to feel that the nursing role was whatever got left over, and also background care. Another problem of multiprofessional work, especially in community settings, seemed to be that the nurse no longer got an overview of the patient or saw their recovery; both learning and a sense of reward could suffer. This fragmentation of the care process led to what we came to call 'broken stories' (*'nurses do little chunks now'* – staff nurse). We conclude that this made the practice justification processes (both cognitive and affective aspects) more difficult, and therefore less accessible to the student nurse on placement. The influence seems to be particularly strong where students on placement no longer 'see the whole story' because whole stories no longer exist, or where they do not see people getting well again. We conclude that where these intrinsic rewards of the emotional side of professional work are perhaps less available, it will be to the detriment both of education and of professional practice.

11.2.2 Economies of performance and ecologies of practice

We came to see a pattern in the espoused theory and theory in use claims that were made and began to deploy the terms 'economy of performance' and 'ecology of practice' in order to foreground the main conflicts of interests and registers that seemed to characterise professionals' talk about their work. Such a vocabulary also helped us to get away from more static notions such as 'discourse' and 'regime'.

The notion of an 'economy' is useful because it broadens out the ways in which people may participate, compared to the more determinist implications of 'regime'. It channels rather than coerces, and allows the decisions of individuals a degree of influence on the working and shape of the 'model' itself. The notion of an 'economy of performance' refers to the sorts of mainly quantitative indices that determine an effective or ineffective performance. They are the indices of accountability. The wider aspects of markets, league tables, also fit the metaphor very well. We conclude that they define professional work as an 'economy of performance' which has consequences for individual professionals as well as corporate consequences for institutions. They express the individual's engagement with the audit culture, offering an evaluation of performance, and a scale for the measurement of 'improvement' as well as future targets. Strathern (2000) adds to our concern that national competencies and audits should not be seen to simply mirror the role for an outside public's scrutiny. Citing Tsoukas, she concludes that *'institutionalised second order description'* results in *'more information'* but less *'trust'*, and so there

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develops *'the self-defeating specification of indicators'* (Strathern, 2000: 314). Her conclusion follows that of Tsoukas, that *'the ideal of transparency ... undermines the trust that is necessary for an expert system to function effectively'* (Tsoukas 1997: 835). Such economic ideals create imbalance and separation in a self-balancing cohesive world. Thus, we argue that, in practice, such approaches are ecologically illegitimate in conception and unsustainable over time. As has been seen, our data suggested that such 'economic' registers were often strongly resisted.

The 'ecology of practice', on the other hand, refers to those more voluntaristic aspects of practice that express the choices and affiliations that professionals make individually and collectively. However, professionals did not seem to belong to one register or the other, but 'traded' differently between them, complaining, borrowing, adapting, reviving, rejecting, distancing, owning, comparing, judging and so on. Implicit in this sense of the professional as a complex and contradictory entity, located in differing and sometimes opposing registers of 'economy' and 'ecology', is the possibility of developing much more complex notions of professionalism and of professional identity. Overall, it is also possible to consider how economic discourses 'leak' into ecological ones, thereby embedding change, discursively at least. The boundary between the 'economy of performance' and the 'ecology of practice' is relatively open. Change can be experienced as a normal, rather than a pathological event. These processes are reflected in changes in justification practices, sometimes from the individual *'it works for me'*) to the collective (*'we're used to change around here'*; *'come on let's give it a try'*. As some of our case study data and educational vignettes suggest, the main reference can become a collective one. These leakages and rationalisations can also become embedded in collective ways – as a community of practice, or a language of development, or indeed resistance.

11.3 The dynamics of groups, the dynamics of change

Where does such theorising take us? In conceptual terms, we argue that we have a way of understanding teamwork which is contextual. That contextualisation is not a matter of the immediate location of the co-operating group, which we refer to as the 'micro-context'. Instead, the notions of 'economy of performance' and 'ecology of practice' allow us to read the macro-context (e.g. medical and nursing discourse, policy implementation) in terms of the individual (identity, role) and also the collective (group, discipline). That reading is not so much contextual in relation to the individual and the group, as constitutive. We have, therefore, a theory of teamworking that does not rest simply on the properties and qualities of the group members. We argue that we have extended the work of Miller et al. (1999) on teamworking, and that we can now offer a way of 'reading' groups that does not over-simplify them into 'good' and 'bad' characteristics, and which can be used by student nurses in learning how to deconstruct the groups they either read about in case studies, or experience on placements. We conclude that while such a theory has its limitations, it does offer the student, or practitioner, a research-based 'working theory' with which to analyse situations.

Such a way of reading professional activity also avoids the sorts of 'utopianism' that we have earlier criticised as marking the nursing research of Eraut et al. (1995), Phillips et al. (1994) and Miller et al. (1994), (Stark et al., 2000). It allows us to politicise the relations between different groups and to acknowledge that imbalances of power and knowledge are inherent in the functioning of multiprofessional teams and need to be understood in their specific and general manifestations. The importance of the *'socio-political context'* (Simpson, 1999: 24) is foregrounded. Similarly, the tendency to offer lists of necessary *'skills'* (e.g. Norman et al., 1996: 142) and to look for a single definition of the *'desirable attributes of nurses'* (1996: 141) makes for the same sort of homogenising effect, where singular solutions are held to resolve the problems of professional practice in an age of organisational turbulence. The apolitical nature of these formulae can be illustrated in the work of Norman et al. (1996), where conflicts and contradictions are spirited away via idealising concepts like *'collaborative skills'* or *'assertiveness skills'*. Our suspicion would be that the sort of solution that Sackett et al. (1997) have in mind, where the *'evidence-based'* formula is *'universally applicable throughout the health professions'* (Sackett

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et al., 1997: 17) is something of a delusion, in that the possible scope for 'evidence-based' practice is considerably less, and that the *'level playing field'* (Woolf et al., 1996: 514) that it purports to offer may contain more than a few bumps. *'Intuition'* may be more difficult to abolish than proponents of evidence-based practice intuit (Murphy, 1997: 2).

There are further implications for education. Thus far, the recent history of mental health nursing has seen an increasing philosophical and curricular homogenisation, in terms of specifying the competencies that need to be attained, constructing and tightening national guidelines in ways that have already occurred in other professions such as school teaching, the practice of law and more recently, medicine. Similarly, many of the public service professions are being held accountable by external systems of monitoring, as part of what has recently been named the *'audit culture'* (Power, 1997). Internal governance processes that now include responsibilities for both financial and clinical governance increasingly regulate the organisation of professional practice. An unintended effect of these processes of inspection, control and 'continuous improvement' is that qualities such as diversity tend to be regarded as anomalies, and that the specific interests of users and the differences in local situations are neglected. We have argued that unity (in national and professional purpose) is best achieved by embracing such diversity.

However, in making this argument, two simultaneous 'ownership' problems are highlighted. The first is in regard to the design and delivery of the curriculum. The second is in the response to external accountability, where quantitative indices become replacements for more intangible properties – in the context of mental health nursing for example, the concept of building and maintaining a range of 'relationships'. We conclude that the sort of overt conformity and covert resistance/subversion that audit cultures generate may militate against the reality (as opposed to the appearance) of 'effectiveness'. The call for more consistency may be a mistaken one (e.g. Thomas and Bond, 1995). The sorts of knowledge maps that Eraut et al., (1995) prescribe are attractively definitive in appearance, but objectives such as the *'need for clear and realistic goals for the whole programme which specify the level of competence expected at registration and expectations for the use of scientific knowledge in assessing clients and delivering appropriate care'* (1995: 106) may be easier to state than to meaningfully achieve, and may seriously neglect the relationship sides of nursing and the relationship transformation dynamic of teamworking (Warne, 1999).

11.4 Dream catchers

Our curriculum and policy analysis indicated the relocation of nursing into HE, where apprenticeship models of training were being downplayed, and the critical and reflective practitioner was highlighted. Paradoxically, in a comparable professional training process, school teaching, the opposite has been happening. Bad practices have been encapsulated in 'reflective practitioner' modes, and the competency-based apprenticeship has been relocated into the practical arena of the classroom. The research basis for either of these two ideological approaches to professionalism seems scant (Hartwell, 1996). Various 'common-senses' were invoked in order to justify these very different practices. It is interesting now to see the nursing model move back closer to the current teaching one, adopting a set of competencies as the curricular foundation, and re-asserting the importance of placement learning. Multiprofessional education is of course caught up in these same debates, as either something that can be 'taught' (via social psychology, interpersonal skills education), or something that can only be 'caught' – a product of relatively prolonged placement experience where student nurses can make relationships, see how different disciplines relate to each other, and come to grounded conclusions about their role, its problems and possibilities.

At first we argued that there was a 'pendulum effect' within these sorts of policy dynamic. For example, with each move towards an HE-based nurse education, the anomalies accumulate: distance from practice, different mission of HE compared to NHS, poor

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opportunities for clinical guidance, and so on. In the opposite direction, the school teaching profession's reforms accumulated contradictions: partnerships between school and HE that were partly fictional, inherent second priority of student learning in schools for supervising teachers, lack of reward for such supervision. We argued that in the inclusive ecosystem of nurse education and nursing practice, both policy logics would accumulate contradictions until such time that countervailing pressures from policy-makers, managers and professionals would reverse the policy, or at least reform it extensively through revision or 'relaunch'.

Perhaps a more useful analogy to illustrate this countervailing process could be found within rugby league rules. The 'turnover' rule decides that possession of the ball goes to the other side after six tackles. In this way, policy reversals and revisions become part of the dynamic of policy development. That is, a principle of illogic is built into the logic of development. That principle is a generating force in the 'turbulence' and 'policy hysteria' that characterises periods of rapid change and hyper-active government. It leads to successive and evanescent policy scenarios concerning the identity, role and function of the nurse in contemporary situations and a consequent set of stipulations as to how the nurse – in this case the MHN – should relate to other professionals and stakeholders in the care process.

It would be our prediction that the evidence-based 'turnover' – in relation to mental health nursing at least – would be subject to a swift accumulation of contradictory findings: resource crises, lack of time at practitioner levels, relational nature of mental health nursing, bed occupancy skews, staff shortages and so on. The attempt to make the professional role more rationally based in an organisational world that is in increased flux and pressure is unlikely to succeed except at the rhetorical level – for example, as an expression of competencies that all MHNs should understand and be able to demonstrate, including those relating to teamwork.

The multiprofessional team is likely to reflect these confusions, and coherence will remain a matter of local accomplishment rather than national prescription. We would also argue that the attempt to define, as it were, the 'universal nurse', a 'national curriculum', 'core competencies', 'the effective multiprofessional team' and indicative personal and professional qualities is a homogenising 'turnover' that will accumulate contradictions rather quickly, and which may not be suitable for the diverse, plural and unpredictable world of future care.

This is not to suggest a further 'turnover' emphasising only diversity and local definitions of need, but is a cautionary note about how policies accumulate illogics, and why research-based practice is needed at policy levels more than it is at practitioner levels, where the conditions for its implementation often do not seem to exist. As we noted above, the determination of what constitutes evidence or research still reflects the dominant medical model paradigm. In the recently published NSF (the current definitive policy guidance), 223 referenced texts are used to support the formulation of these policy objectives, and 80% are represented by the adherence and promotion of a positivist paradigm. In the context of MHN training, the NSF recommends that future training reflects the NSF priorities in a way that promotes lifelong learning and reflective practice. A fast track national programme is envisaged that uses 'focused education', i.e. competencies which address critical skill gaps. The implication is that these rather generalised prescriptions can in some way be implemented and audited in terms of effectiveness of outcome.

In relation to our data there are two other connections to be made here. 'Good teamwork' formulae reflect the same kind of auditable generalisation. They are universal indicators, offering a *'timeless proposition'* of their truth (Strathern, 2000: 318). Strathern goes on to argue that the contradiction between these *'timeless'* propositions and *'real-time'* phenomena sets up *'unpredictable and probably oscillating'* effects for policy and practice. We have already offered a theory of those oscillations in proposing the policy 'turnover'. The second connection involves the over-rational and under-affective nature of evidence-based approaches to professional practice. Our data clearly showed a crisis of identity and morale for MHNs in relation to their own role, which was felt most keenly in multiprofessional team situations. Given the high

emotional investment required of MHNs (Barker et al., 1998), it is surprising how little attempt is made to *'educate the emotions'* of the professional, especially given the prominence of research in this area in the last few years (e.g. Goleman, 1995). Mental health nursing seemed to us to suffer less from under-informed minds than from mismanaged hearts. And 'hearts', we argue, are even less susceptible to universal prescription than minds. This example of policy (for both education and practice) is rendered impotent by its rhetorical exhortations and despite the plethora of 'good practice examples', by a lack of recognisable exemplars.

11.5 Summary

There appears to be a number of conflicts and contradictions in the policy, educational and practice arenas of mental health nursing. Indeed, Hewison and Wildman (1996) note the *'paradigmatic incompatibility'* between nursing, education and managerial discourses and practice (1996: 757). Each of these arenas has experienced rapid and unpredictable change, divergent forces and contradictory interests. The resulting 'turbulence' in the work context gives rise to disjunctions and tensions in and between political, educational and professional discourses, theories and practices. Each of these arenas provided 'smoothing mechanisms' in the form of current rhetoric, procedures and 'partnership' strategies. But, as the smoothing mechanisms jolt against a reality which is often chaotic and messy – the blame cultures, professional tribalism and in-fighting – a 'whiplash' affect can emerge in the form of utopian vision and further gaps between policy, educational and practice arenas.

The unfortunate consequence of 'turbulence' is the fragmentation and contradictory beliefs expressed by individuals experiencing it. In mental health nursing, an interesting contrast emerges between education, which is consciously trying to empower, and practice, which is disempowering. This, however, is not an unusual situation in contemporary professional education, where *'trends are both complex and ambivalent'* (Edwards, 1997: 163) and where the flexible worker, able to adapt to these complexities, is the cure for all ills.

The resulting turbulence is spirited away in invocations of the ideal, as a resolution of what just might need to be read as irresolvable conflict (at the moment at least). Our fear would be that these research initiatives might falter because of this structured disregard for the politics of nursing education and practice in current organisational environments.

The study was to advise the Board of the implications of the mental health context for educational provision. Education alone cannot smooth the turbulence, but maybe it can help practitioners to understand what causes the turbulence and what the effects of turbulence are. As a result some questions arise.

- Can (should) educators teach students for such a messy reality?
- Can we offer students insights into the insulated stories, the separate logics, unintended outcomes and competitive interactions, as well as the more idealistic notions of effective teamworking for quality mental health care?
- How do we achieve the 'aha!' of learning about and for teamwork?
- Will this learning lead to a dilution and distortion of mental health care or dynamic and directed service?
- In doing so, might some of the issues highlighted here, represented by the contradictions inherent in bringing together policy, practice and education, be avoided in the future preparation of the MHN for multiprofessional teamworking?

Multiprofessional teamworking, multidisciplinary, interprofessional teamwork and so on are part of a healthy rhetoric, but there is little hard evidence of institutional transformations based on these ideas and practices. In particular, it is often interesting to ask if the proponents of 'multiprofessional teamwork' actually employ that model as part of their own institutional practice. We suggest that in failing to address issues raised in this study, these same factors may

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result in a 'Bermuda Triangle' (Warne et al., forthcoming) being created, within which the needs of service users may disappear.

11.6 Implications

Our findings stressed the need to locate nursing practices and educational preparation within a broad understanding both of the changing identity of the mental health nurse, and of the 'turbulent' nature of the context. We saw these as 'nested' concerns. The following should also be read as a related constellation of changes, rather than as single and specific items which might be separately implemented.

11.6.1 Multiprofessional multi-agency teamwork and educational implications

1. We confirm previous research that suggested that teamwork may be more effectively 'caught' than 'taught'. Experiential placements, case studies, educational vignettes and role-play will assist such learning. We found, however, that there were limited opportunities to learn from effective teamwork, even on prolonged placement. Due to various occupational pressures on the work force, learning-rich placements in this area were not common. Short placements were unsuitable for this sort of learning. We support recent UKCC and Board suggestions that students undertake longer placements earlier in the pre-registration programme. Such earlier initiation into the practice of the role is also likely to promote a sense of emotional identity as a beginning professional. That emotional identity is necessary to the subsequent development of teamwork approaches. Learning audits, therefore, must attend to 'real' opportunities to 'catch' multiprofessional work.
2. Effective teams often rely on individuals being able to 'span' boundaries. These boundaries cross disciplines, and also levels of policy and practice. There should be greater organisational awareness of such individual roles at macro, meso, and micro levels of policy and practice development, and endorse National Service Framework (DoH, 1999a) recommendations for changes in current management development programmes.
3. We find that teamworking is often imposed on work groups without sufficient attention to teambuilding. Students, therefore, are quite likely to experience teamwork as interprofessional 'blaming', or as fragmented inputs. More attention should be given to teambuilding in work contexts.
4. Teamwork rhetoric stresses the collaborative nature of work. Actual examples were more likely to reflect traditional medical models of health care. More collaborative patterns of teamwork should be promoted, and students should learn how to read the distribution of power and authority in groups.
5. Teamworking is not easily taught as a separate subject. It receives little priority from students. It is important, therefore, that teamwork-focused case studies, educational vignettes and assignments should combine such learning with technical nursing issues and user perspectives.
6. Teamwork issues are carried, albeit in small measure, in a curriculum whose modular structures do not model teamwork. We conclude that overall programme rationales find little expression in modular provision and that the curriculum is usually fragmented. The absence of visible teamwork in educational provision carries powerful messages to students.
7. There is some evidence to suggest that 'shared learning' does not achieve multiprofessional benefits, in line with previous research. Causes were large numbers, inappropriate pedagogy, and lack of uptake by professionals other than nurses.

We suggest that 'shared learning' cannot be seen on its own as leading to multiprofessional benefits.

8. We find that diagnoses and prescriptions for multiprofessional multi-agency practices, or preparations, are over-generalised. These need to be better situated in the actual experiences of mental health nurses in specific work contexts. Such generalisations often refer to work and teamwork conditions that nurses do not actually experience. Such idealisation may be motivated by a desire for education-led improvements in professional practice, but may also result in a damaging gap between ideal and real practice.

9. We find that 'evidence-based' approaches to teamwork learning, or practice, have to be regarded cautiously. Reliable and valid formulae for best practice do not exist, and may not exist in the future. In this area, evidence-based practice must remain an orientating question rather than a definitive prescription.

10. Our findings stress the dynamic and difficult connections between teamwork, role identity, and work context. The emotional costs of the role are not fully addressed by 'evidence-based' approaches to professional work, which stress the rational and procedural nature of work. More account needs to be taken of the affective nature of the nurse's work, both in terms of stress and in terms of vocational commitment.

11. Policy and educational curricula relating to multiprofessional multi-agency work seem often to be formulated by those remote from work contexts. Greater involvement of practitioners, at all levels, is desirable, as is the greater involvement of users.

12. We conclude that terms such as 'collaboration', 'partnership' and 'teamworking' are difficult to understand and bring about unless issues of power, status, authority and competition between disciplines and within hierarchies are made part of professional learning at pre- and post-registration levels.

13. We offer the notions of 'economy of performance' and 'ecology of practice' as ways of understanding the tensions and contradictions of the mental health role in times of change. We believe that students could and should, be taught, via case studies and educational vignettes, to understand the conflictual pressures of professional performance in contemporary conditions of continuous change. Such an understanding might help students avoid the sorts of 'ideal versus real' schisms that can lead readily to cynicism. It might also help managers to understand the sorts of dilemmas continuous change and conflicting demands place on professionals in health settings.

14. Some problems of multiprofessional learning, especially at the pre-registration phase, are soluble only with smaller cohorts, staggered intakes, and more generic approaches to professional education. There is clear evidence that considerations of cost act against educational effectiveness in this area.

15. The evidence is clear that practitioners, educators and students generally agreed that a shorter common foundation programme and an earlier introduction of specific mental health inputs were desirable in the pre-registration programme.

16. The development of programmes remains uniprofessional. We support the logic of different professions contributing equally to the development of multiprofessional and multi-agency programmes, as is beginning to happen in post-registration programmes.

11.6.2 Policy issue

17. Our study has implications for understanding some of the dynamics of policy change in mental health settings. We posit that policy directions tend to accumulate sufficient illogic and contradiction to prompt their periodic reversal, and apply this to the higher education versus 'apprenticeship' debate. The danger of overreacting to such 'pendulum' swings is asserted.

11.6.3 Evidence- and research-based practice

18. Evidence-based approaches to professional practice need to be accompanied by evidence-based approaches to policy and management. We note a disjunction in these different arenas of work, and suggest that research-based approaches are most needed at policy levels.

11.6.4 User involvement

19. On the basis of our research, we conclude that service user involvement, in many aspects of mental health care, is minimal. Barriers to inclusion are poorly understood and we suggest further research in this area. We advocate a greater involvement of the user or ex-user in policy, practice and educational contexts.

20. There is little evidence that multiprofessional, multi-agency approaches actually benefit the user, directly or indirectly. While the mediated nature of such benefits is clear, and the difficulty of comparison considerable, it would be desirable to evaluate more certainly the efficacy of such approaches. Research into teamworking may benefit from multiprofessional multi-agency commissioning.

11.6.5 General issues

21. The evidence suggested that notions such as 'competencies', 'audit' and 'accountability' can oversimplify the nature of work outcomes and skew professional delivery towards readily measurable outcomes. Both in practice and in professional preparation, the limits of the usefulness of these approaches need to be understood and shared with learners.

22. More generally, we are convinced that the 'turbulent' nature of policy, practice and educational contexts means that prescriptions for best practice are often expressed in unrealistic and utopian terms. Education needs to become more focused on the messy realities of care, as well as collaboration.

23. We are not persuaded that the trend towards universal prescription (national specification of competencies, role definitions, etc.) is desirable. Diversity of provision, reasonably based, carries with it the prospect of a variety which may be optimal for a system in circumstances of rapid change. It also offers a greater prospect of local relevance, user involvement, and the more certain 'ownership' of programme philosophy.

REFERENCES

Adams, T. (1991) Paradigms in psychiatric nursing. *Nursing: The Journal of Clinical Practice, Education and Management*, 4, 35, 9-11.

Allsop, J. (1984) *Health Policy and the National Health Service*. London: Longman.

Alter, C. and Hage, J. (1993) *Organisations Working Together*. London: Sage.

Altschul, A.T. (1973) A multidisciplinary approach to psychiatric nursing. *Nursing Times*, 69, 15, 508-11.

Ansoff, I. (1990) *Implanting Corporate Strategy*. London: Prentice Hall.

Argyris, C. and Schön, D. (1978) *Organisational Learning: A Theory of Action Perspective*. Massachusetts: Addison Wesley.

Arney, W.R. and Bergan, B.J. (1984) *Medicine and the Management of Living: Taming the Last Great Beast*. Chicago: University of Chicago Press.

Ashton, J. (2000) *Public Address Concerning the Introduction of Health Development Agencies*. Cheshire: North West NHS Executive.

Audit Commission (1994) *Finding a Place*. London: Audit Commission.

Barker, P. (1990) The conceptual basis of mental health nursing. *Nurse Education Today*, 10, 5, 339-348.

Barker, J. (1996) A methodology for evidence based health policy making: The Welsh protocol enhancement project. *Topics in Health Information Management*, 17, 2, 1-17.

Barker, P. (1998) The future of the theory of interpersonal relations? A personal reflection on Peplau's legacy. *Journal of Psychiatric and Mental Health Nursing*, 5, 213-220.

Barker, P., Keady, J., Croom, S., Stevenson, C., Adams, T., Reynolds, W. (1998) The concept of serious mental illness: modern myths and grim realities. *Journal of Psychiatric and Mental Health Nursing*, 5, 4, 247-254.

Barker, P., Jackson, S., Stevenson, C. (1999) What are psychiatric nurses needed for? Developing a theory of essential nursing practice. *Journal of Psychiatric and Mental Health Nursing*, 6, 273-282.

Barr, H., Hammick, M., Koppel, I., Reeves, S. (1999) Evaluating interprofessional education: two systematic reviews for health and social care. *British Educational Research Journal*, 25, 4, 533-544.

Bass, B. (1990) From transactional to transformational leadership: learning to share the vision. *Organisational Dynamics*, 18, 19-31.

Beattie, A. (1995) War and peace among the health tribes. In: Soothill, K., Mackay, L., Webb, C. (eds) *Interprofessional Relations in Health Care*. London: Edward Arnold.

Beese, J. and Turnbull, J. (1996) CPNs in court trap. *Nursing Management*, 2, 8, 18-20.

Beresford, P. and Trevillion, S. (1996) *Developing Skills for Community Care: A Collaborative Approach*. Aldershot: Arena.

Bergen, A., Cowley, S., Young, K., Kavanagh, A. (1996) *An Investigation into the Changing Needs of Community Nurses with regards to Needs Assessment and Quality of Care in the Context of the NHS and Community Care Act 1990*. London: ENB.

Berragan, L. (1998) Nursing practice draws upon several different ways of knowing. *Journal of Clinical Nursing*, 7, 209-217.

Best, S. and Kellner, D. (1991) *Postmodern Theory: Critical Interrogations*. New York: The Guilford Press.

Biott, C., Edward, S., Easen, P. (1997) *Reflective practice in multiprofessional contexts: visibility, cultures and structures*. Paper delivered to the British Educational Research Conference, York, September.

Booth, A. (1996) *Guide to evidence based practice*. SCHARR Occasional Paper 2. Sheffield: Sheffield Centre for Health and Related Research.

Botelho, R. (2000) The UK healthcare renaissance: a transatlantic perspective. *Journal of Interprofessional Care*, 14, 1, 87-93.

Bowers, L. (1992) Ethnomethodology II a study of the community psychiatric nurse in the patient's home. *International Journal of Nursing Studies*, 29, 69-79.

Bowers, L. (1994) Organisation and management of community care. *Mental Health Nursing*, 14, 4, 8-11.

Bratman, M. (1992) Shared co-operative activity. *Philosophical Review*, 2, 101, 327-341.

Brindle, D. (1998) Comment. *The Guardian*, 15/7/98.

Burnard, P. (1989) Experiential learning and andragogy – negotiated learning in nurse education: a critical appraisal. *Nurse Education Today*, 9, 300-306.

Burns, T. and Priebe, S. (1999) Mental health care failure in England: Myth and reality. *British Journal of Psychiatry*, 174, 191-192.

Butterworth, T. (1987) Psychiatric nursing: fumbling in a vacuum, or grasping at an opportunity. *Mental Health Nursing*, 1, 7.

Butterworth, T. (1994) Working in partnership: a collaborative approach to care. The review of mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 1, 1, 41-44.

Butterworth, C.A. and Skidmore, D. (1981) *Caring for the Mentally Ill in the Community*. London: Croom Helm.

Calnan, M. (1987) *Health and Illness: The Lay Perspective*. London: Tavistock.

Campbell, P. (1996) Working with service users. In: Sanford, T. and Gournay, K. (eds) *Perspectives in Mental Health Nursing*. London: Baillière Tindall.

Capra, F. (1996) *The Web of Life*. London: Harper Collins.

Carlile, G. (1996) Telling it like it is. *Nursing Times*, 92, 10, 50-52.

Chalk, A. (1999) Community mental health teams: reviewing the debate. *Mental Health Nursing*, 19, 2, 12-14.

Chan, P. and Rudman, M. (1998) Paradigms for mental health nursing: fragmentation or integration. *Journal of Psychiatric and Mental Health Nursing*, 5, 2, 143-146.

Charan, R. (1991) How networks reshape organisations for results. *Harvard Business Review*, September-October, 123-140.

Cohen, M. (1998) Users' movement and the challenge to psychiatrists. *Psychiatric Bulletin*, 22, 155-157.

Cole, M. and Perides, M. (1995) Managing values and organisational climate in a multi-professional setting. In: Soothill, K., Mackay, L., Webb, C. (eds). *Interprofessional Relations in Health Care*. London: Edward Arnold.

Coleman, R. (1996) *The politics of the illness model of voices*. The Construction of Psychiatric Authority Conference. Newcastle: University of Newcastle.

Cook, D., Meade, M., Fink, M. (1996) How to keep up with critical care literature. *Critical Care Medicine*, 24, 10, 1757-1768.

Cormack, D. (1983) *Psychiatric Nursing Described*. Edinburgh: Churchill Livingstone.

Corrigan, P. and Garman, A. (1999) Transformational and transactional skills for mental health teams. *Community Mental Health Journal*, 35, 4, 301-312.

Corrigan, P., Holmes, E., Luchins, D. (1995) Burnout and collegial support in state psychiatric hospital staff. *Journal of Clinical Psychology*, 51, 703-710.

Cowley, S., Bergen, A., Young, K., Kavanagh, A. (1996) Establishing a framework for research: the example of needs assessment. *Journal of Clinical Nursing*, 5, 53-61.

Cuban, L. (1990) Reforming again, again, again. *Educational Researcher*, 19, 1, 3-13.

Dear, M. and Taylor, S. (1982) *Not on Our Street: Community Attitudes to Mental Health*. London: Pion.

Department of Health (1990) *The National Health Service and Community Care Act*. London: HMSO.

Department of Health (1994) *Working in Partnership: A Collaborative Approach to Care*. Report of the Mental Health Nursing Review Team. London: HMSO.

Department of Health (1995) *The Mental Health [Patients in the Community] Act*. London: HMSO.

Department of Health (1997a) *The New NHS: Modern, dependable*. London: HMSO.

References

Department of Health (Welsh Office) (1997b) *Mental Health Act Code of Practice*. (2nd ed.) London: HMSO.

Department of Health (1998) *Modernising Mental Health Services*. London: HMSO.

Department of Health (1999a) *Our Healthier Nation: Mental Health National Service Framework*. London: HMSO.

Department of Health (1999b) *Reform of the Mental Health Act 1983*. London: HMSO.

Department of Health (1999c) *Saving Lives: Our Healthier Nation*. London: HMSO.

Department of Health (1999d) *The Health Act*. London: HMSO.

Department of Health/Social Services Inspectorate (1995) *Building Bridges*. London: HMSO.

Department of Health/Social Services Inspectorate (1999) *Still Building Bridges; The Report of a National Inspection of Arrangements for the Inspection of Care Programme Approach with Care Management*. London: HMSO.

Dietrich, G. (1978) Teaching psychiatric nursing in the classroom. *Journal of Advanced Nursing*, 3, 528-534.

Dobson, F. (1998) *Frank Dobson outlines third way for mental health*. DoH Press Release, 98/311 29/7/98. London: Department of Health.

Doyle, L. (1998) Crossing professional boundaries. *Nursing Management*, 5, 4, 8-10.

Du Toit, D. (1995) A sociological analysis of the extent and influence of professional socialisation on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing*, 21, 164-171.

Duggan, M. (1997) *Pulling Together: The Future Roles and Training of Mental Health Staff*. London: The Sainsbury Centre for Mental Health.

Dyer, W. (1995) *Team Building: Current Issues and New Alternatives*. Boston: Addison Wesley.

Edwards, K. (1995) A preliminary study of users' and nursing students' views of the role of the mental health nurse. *Journal of Advanced Nursing*, 21, 2, 222-229.

Edwards, M. (1997) Powerlessness, oppression and women. *Mental Health Nursing*, 217, 3, 10-20.

Emerick, R.E. (1991) The politics of psychiatric self-help; political factions, interactional support, and group longevity in the social movement. *Social Science and Medicine*, 32, 10, 1121-1128.

English National Board for Nursing, Midwifery and Health Visiting (1994) *Creating Lifelong Learners. Guidelines for programmes leading to the qualification of Specialist Practitioner*, London: ENB.

English National Board for Nursing, Midwifery and Health Visiting (1996) *ENB Regulations and Guidelines for the Approval of Institutions and Courses*. London: ENB.

English National Board for Nursing, Midwifery and Health Visiting (1997) *Mental Health Nursing. Working in partnership*. London: ENB.

English National Board for Nursing, Midwifery and Health Visiting (1999) *The Acquisition of Key Skills for Mental Health Nursing Practice*. Official letter, April, London: ENB.

Eraut, M., Alderton, J., Boylan, A., Wright, A. (1995) *Learning to Use Scientific Knowledge in Education and Practice Setting: an evaluation of the contribution of the biological, behavioural and social sciences to pre-registration nursing and midwifery programmes*. London: ENB.

Evandrou, M. and Falkingham, M. (1998) The personal social service. In: Glennerster, H. and Hills, J. (eds) *The State of Welfare: the economics of social spending*. (2nd ed.) Oxford: Oxford University Press.

Everett, B. (1998) Participation or exploitation? Consumers and psychiatric survivors as partners in planning mental health services. *International Journal of Mental Health*, 27, 1, 80-97.

Evidenced Based Medicine Working Group (1992) Evidence based medicine a new approach to teaching the practice of medicine. *Journal of The American Medical Association*, 288, 17, 2417-2424.

Fairhurst, E. (1998) Suffering, emotion and pain: towards a sociological understanding. In: Carter, B. (ed.) *Perspectives on Pain: Mapping the Territory*. London: Arnold.

Fitzpatrick, J.M., While, A.E., Roberts, J.D. (1996) Key influences on the professional socialisation and practice of students undertaking different pre-registration nurse education programmes in the United Kingdom. *International Journal of Nursing Studies*, 33, 5, 506-518.

Flax, J. (1990) Postmodernism and gender relations in feminist theory. In: Nicholson, L.J. (ed.) *Feminism/Postmodernism*. New York: Routledge.

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Ford, R. and Ryan, P. (1997) Labour Intensive. *Health Service Journal*, 107, 5537, 26-29.

Ford, R., Durcan, G., Warner, L. (1998) One day survey by the Mental Health Act Commission of acute adult psychiatric inpatient wards in England and Wales. *British Medical Journal*, 317, 1279-1283.

Foucault, M. (1975) *Madness and Civilisation*. London: Tavistock.

Fretwell, J.E. (1987) An enquiry into the ward learning environment. *Nursing Times*, 76, 16, 69-73.

Gagliardi, A. (1996) Ontario health care evaluation network: building partnerships and promoting evidence based practice. *Canadian Journal of Nursing Research*, 28, 3, 145-149.

Gallop, R. (1997) Caring about the client: the role of gender, empathy and power in the therapeutic process. In: Tilley, S. (ed.) *The Mental Health Nurse: Views of Practice and Education*. Oxford: Blackwell Science.

Gellerman, S. (1974) *Behavioural Science in Management*. Harmondsworth, Middlesex: Penguin.

Gijbels, H. (1995) Mental health nursing skills in an acute admission environment: perceptions of mental health nurses and other mental health professionals. *Journal of Advanced Nursing*, 21, 460-465.

Gill and Ling (n.d.) *Interprofessional shared learning: a curriculum for collaboration*.

Girvin, J. (1998) Pointers to the future ... primary health care team. *Nursing Management*, 4, 9, 8-9.

Gittins, D. (1998) *Madness in its Place: Narrative of Severalls Hospital, 1913-1997*. London: Routledge.

Glaser, B.G. and Strauss, A.L. (1967) *The Discovery of Grounded Theory. Strategies for Qualitative Research*. New York: Aldine Publishing Co.

Glenister, D. (1997) Coercion control and the mental health nurse. In: Tilley, S. (ed.) *The Mental Health Nurse: Views of Practice and Education*. Oxford: Blackwell Science.

Glover, G., Robin, E., Emmi, J., Arabscheibanni, G. (1998) A needs index for mental health care. *Social Psychiatry and Psychiatric Epidemiology*, 33, 89-96.

Goffman, E. (1958) *Report on a study of St Elizabeth's Hospital Washington*. Walter Reed Army Institute of Research Symposium on preventive and social psychiatry. US Government Printing Office.

Golan, N. (1978) *Treatment in Crisis Situations*. London: Macmillan.

Goleman, D. (1995) *Emotional Intelligence*. New York: Bantham Books.

Goodwin, S. (1997) *Comparative Mental Health Policy*. London: Sage.

Gournay, K. (1997) Commentary responses to: "What to do with nursing models". *Journal of Psychiatric and Mental Health Nursing*, 4, 3, 227-231.

Gunn, J. (1990) Clinical approaches to the assessment of risk. In: Carson, D. (ed.) *Risk Taking in Mental Disorder: Analyses, Policies and Practical Strategies*. Chichester: SLE Publications.

Gyorkos, T.W., Tannenbaum, T.N., Abrahamowicx, M., Oxman, A.D., Scott, E.A.F., Millson, M.E., Rasooly, I., Frank, J.W., Riben, P.D., Mathias, R.G., Best, A. (1994) An approach to the development of practice guidelines for community health interventions. *Canadian Journal of Public Health*, 85, Suppl 1, S8-13.

Hammersley, M. (1997) Teaching as a research based profession: prospects and possibilities. *British Educational Research Journal*, 23, 3, 141-161.

Handy, C. (1975) *Understanding Organisations*. Harmondsworth: Penguin.

Handy, C. (1993) *The Age of Unreason*. London: Unwin.

Handy, C. (1995) *Waiting for the Mountain to Move*. London: Arrow.

Hannigan, B. (1998) Fragmentation or integration? *Mental Health Nursing*, 18, 1, 4-6.

Hargreaves, D. (1997) In defence of research for evidence based teaching: a rejoinder to Martyn Hammersley. *British Educational Journal*, 23, 4, 405-419.

Harrison, G. (1997) Risk assessment in a climate of litigation. *British Journal of Psychiatry*, 170, 37-39.

Hartwell, A. (1996) *Scientific Ideas and Education in the 21st Century*. Washington: Institute for International Research.

Haywood, S. and Alaszewski, A. (1980) *Crisis in the Health Service: The Politics of Management*. London: Croom-Helm.

References

Health Education Authority. (1997) *Making Headlines: Mental Health and the National Press*. London: Health Education Authority.

Hearn, J., Sheppard, D., Tancred, S., Burrell, G. (1989) *The Sexuality of Organisation*. London: Sage.

Heath, H. (1998) Paradigm dialogues and dogma: finding a place for research, nursing models and reflective practice. *Journal of Advanced Nursing*, 28, 2, 288-294.

Hewison, A. and Wildman, T. (1996) The theory-practice gap in nursing: a new dimension. *Journal of Advanced Nursing*, 24, 754-761.

Hibberd, P.A. (1998) The primary/secondary interface. Cross-boundary teamwork – missing link for seamless care? *Journal of Clinical Nursing*, 7, 3, 274-282.

Higgins, R., Oldman, C., Hunter D. (1996) Working together: lessons for collaboration between health and social services. *Health and Social Care*, 2, 269-277.

Himmelman, A. (1996) On the theory and practice of transformational collaboration. In: Huxham, C. (ed.) *Creating Collaborative Advantage*. London: Sage.

Hiscock, J. and Pearson, M. (1999) Looking inwards, looking outwards: dismantling the 'Berlin Wall' between health and social Services. *Social Policy and Administration*, 33, 2, 150-163.

Hopton, J. (1997) Towards a critical theory of mental health nursing. *Journal of Advanced Nursing*. 25, 3, 490-500.

Hopton, J. and Glenister, D. (1996) Working in partnership: vision or pipedream. *Critical Social Policy*, 16, 2, 111-119.

Humphris, D. and Littlejohns, P. (1995) The development of multi-professional audit and clinical guidelines: their contribution of quality assurance and effectiveness in the NHS. *Journal of Interprofessional Care*, 9, 3, 207-225.

Hunt, M. (1999) Multidisciplinary case notes: an audit. *Mental Health*, 10, 14, 701-703.

Hunter, P. (1960) The changing function of professional staff in the mental hospital. In: *Association of Psychiatric SW Ventures in Professional Cooperation*. London: APSW.

Huxley, P. (1995) Can mental health specialism survive the NHS and community care reforms? *Journal of Mental Health*, 4, 323-327.

Iwasiw, C.L. and Goldenberg, D. (1993) Peer teaching among nursing-students in the clinical area – effects on student learning. *Journal of Advanced Nursing*, 18, 4, 659-668.

Jacka, K. and Lewin, D. (1987) *The Clinical Learning of Student Nurses*. Report No. 6. Nursing Research Unit. London: King's College.

Jacobs, A. (1973) *Critical Behaviours in Psychiatric Mental Health Nursing. Vols 1, 2 and 3*. California: American Institutes of Research.

Jacobson, L., Edwards, A., Granier, S., Butler C. (1997) Evidence based medicine and general practice. *British Journal of General Practice*, 47, 449-452.

James, A. (2000) New mentality. *The Guardian*, 26/1/00.

Jamous, H. and Peloille, B. (1970) Professions or self-perpetuating systems? Changes in the French hospital system. In: Jackson, J. (ed.) *Professions and Professionalization*. Cambridge: Cambridge University Press.

Jodelet, D. (1991) *Madness and Social Representation*. London: Harvester Wheatsheaf.

Jonathan, R. (1993) Education, philosophy and the fragmentation of value. *Journal of Philosophy of Education*, 27, 2, 171-178.

Jones, K. (1961) *Mental Health and Social Policy 1845-1959*. London: Routledge.

Jones, K. (1975) *Mental Health and Society*. London: Routledge.

Jones, K. (1993) *Asylums and After: A Revised History of the Mental Health Services*. London: Athlone Press.

Jones, A. and Kamath, P.D. (1998) Issues for the development of care pathways in mental health services. *Journal of Nursing Management*, 6, 2, 87-95.

Kavenaugh, K.H. (1988) The cost of caring: Nursing on a psychiatric intensive care unit. *Human Organisation*, 47, 3, 242-251.

Kettles, A.M. (1998) *A profession without a career*. Paper presented at the fourth Nerwork for Psychiatric Nursing Conference, 2-3/9/98.

King's Fund London Commission (1997) *Transforming Health in London*. London: King's Fund.

361 137

Klein, R. (1995) *The New Politics of the NHS*. London: Longman.

Knapp, M., Hallam, J., Beecham, J., Baines, B. (1999) Private, voluntary or public? Comparative cost-effectiveness in community mental health care. *Policy and Politics*, 27, 1, 25-41.

Kotter, J. (1997) Cultures and coalitions. In: Gibson, R. (ed.) *Rethinking the Future*. London: Brearley Publications.

Lacey, C. (1977) *The Socialisation of Teachers*. London: Methuen.

Lather, P. (1991) *Getting Smart: Feminist Research and Pedagogy within the Post Modern*. New York: Patt.

Leana, C. (1987) Power relinquishment versus power sharing: theoretical clarification and empirical comparison of delegation and participation. *Journal of Applied Psychology*, 72, 228-233.

Ledwith, F. (1999) Policy contradiction and collaboration in community mental health services in Britain. *International Journal of Public Sector Management*, 12, 3, 236-248.

Leff, J. (1997) *Care in the Community: Illusion or Reality*. London: Wiley.

Leiba, T. (1997) Inter-professional approaches to mental health care. In: Leathard, A. (ed.) *Going Inter-professional*. London: Routledge.

Light, D. (1998) Managed care in a new key: Britain's strategies for the 1990s. *International Journal of Health Services*, 28, 427-444.

Lippman, W. (1922) *Public Opinion*. London: Macmillan.

Lutzen, K. (1998) Subtle coercion in psychiatric practice. *Journal of Psychiatric and Mental Health Nursing*, 5, 2, 101-108.

MacDonald, L.D., Ochera, J., Leibowitz, J.A., McLean, E.K. (1990) Community mental health services from the user's perspective: an evaluation of the Doddington Edward Wilson (DEW) mental health service. *The International Journal of Social Psychiatry*, 36, 3, 183-193.

Machin, T. and Stevenson, C. (1997) Towards a framework for clarifying psychiatric nursing roles. *Journal of Psychiatric and Mental Health Nursing*, 4, 81-87.

Manning, N. and Shaw, I. (1999) Mental health and social order. *Policy and Politics*, 27, 1, 5-11.

Martin, J. (1984) *Hospitals in Trouble*. London: Blackwell.

McBurney, S. (1999) *Ecology into Economics Won't Go*. Devon: Green Books.

McCourt Perring, C. (1997) Community Care as de-institutionalisation? In: Wright, S. (ed.) *Anthropology of Organisations*. London: Routledge.

McCulloch, G. and Boxer, J. (1997) *Mental Health Promotion: Policy, Practice and Partnerships*. London: Ballière Tindall.

McDougal, T. (1997) Patient empowerment: fact or fiction? *Mental Health Nursing*, 17, 1, 4-5.

McFadyen, J. (1997) Mental health advocacy and the path to participation. *British Journal of Health Care Management*, 3, 9, 475-482.

McFadyen, J. and Farrington, A. (1997) Community mental health nurses – muddled, bewildered and confused. *British Journal of Nursing*, 2, 3, 121-126.

McFadyen, J., Farrington A., Piper J. (1998) Community mental health nursing: the interpretation of roles. *British Journal of Health Care Management*, 4, 1, 28-31.

McKee, L., Marnoch, G., Dinnie, N. (1997) *Medical Managers: Puppet-masters or puppets? Sources of power and influence in clinical directorates*. Conference Paper, British Medical Sociology Annual Conference. York.

McNally, J., Cope, P., Inglis, B., Stronach, I.M. (1994) Current realities in the student teaching experience. *Teaching and Teacher Education*, 10, 219-230.

Melia, K. (1987) *Learning and Working: The Occupational Socialisation of Nurses*. London: Tavistock.

Mental Health Task Force User Group (1994) *Advocacy – A Code of Practice*. Heywood: BAPS.

Merton, R.K. (1957) *Social Theory and Social Structure*. London: Free Press.

Meuser, K., Bond, G., Drake, R., Resnick, G. (1998) Models of community care for severe mental illness: A review of research on case management. *Schizopherenia Bulletin*, 24, 37-73.

Middleton, H. and Shaw, I. (1999) Inequalities in mental health. *Policy and Politics*, 27, 1, 43-56.

Miller, J. (1978) *The Body in Question*. London: Jonathan Cape.

References

Miller, R. (1993) *From Dependency to Autonomy: Studies in Organisation and Change*. London: Free Association Books.

Miller, C., Tomlinson, A., Jones, M. (1994) *Learning Styles and Facilitating Reflection*. London: ENB.

Miller, C., Ross, N., Freeman, M. (1999) *Shared Learning and Clinical Teamwork: New Directions in Education for Multiprofessional Practice*. London: ENB.

Mintzberg, H.Y. (1998) Strategy making as a craft. Innovation and management. In: Urabe, K. et al. (eds) *International Comparisons*. Berlin: DeGruyter.

Mohan, J. (1996) Accounts of the NHS reforms: macro, meso and micro level perspectives. *Sociology of Health and Illness*, 18, 5, 675-698.

Mohr, W.K. (1995) A critical reappraisal of a social form in psychiatric care settings: The multidisciplinary team meeting as a paradigm case. *Archives of Psychiatric Nursing*, 9, 2, 85-91.

Morrall, P. (1998) *Mental Health Nursing and Social Control*. London: Whurr.

Moss-Kanter, R. (1990) *When Giants Learn to Dance*. Cambridge, Mass.: Harvard University Press.

Müijen, M., Marks, I., Connolly, J., Audini, B. (1992) Home based care and standard hospital care for patients with severe mental illness: a randomised controlled study. *British Medical Journal*, 304, 794-754.

Murphy, P. (1997) Evidence based care. A new paradigm for clinical practice. *Journal of Nurse-Midwifery*, 42, 1, 1-3.

Newdick, C. (1996) *Who should we treat? Patients and resources in the NHS*. Oxford: Oxford University Press.

NHS Executive (1997) EL(97)1 *The Patient's Charter and Mental Health Services: Implementation Guidance*. Leeds: NHSE.

NHS Executive (1998) *Working Together*. London: HMSO.

NHS Executive (1999) *Making a Difference. Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. London: HMSO.

NHS North West Executive (1999) *North West Mental Health Services – The Configuration Opportunity*. Warrington: NHS North West Regional Office.

Nietzsche, F. (1977) *Twilight of the Gods*. Middlesex: Penguin.

Noble, P. and Rodger, S. (1989) Violence by psychiatric in-patients. *British Journal of Psychiatry*, 155, 384-390.

Nolan, P. (1993) *A History of Mental Health Nursing*. London: Chapman Hall.

Nolan, M., Grant, G., Keady, J. (1996) *Understanding Family Care*. Milton Keynes: Open University Press.

Norman, I., Redfern, S., Bodley, D., Holroyd, S., Smith, C., White, E. (1996) *The Changing Educational Needs of Mental Health and Learning Disability Nurses*. London: ENB.

Norman, I., Peck, E., Richards, H. (1998) *Interprofessional Working in Adult Community Mental Health Services: Setting a Positive Agenda*. London: King's Fund.

Nyatanga, L. (1998) Professional ethocentrism and shared learning. *Nurse Education Today*, 18, 175-177.

Ogier, M. (1981) The influence of ward sisters upon nurse learners. *Nursing Times Occasional Paper*, 77, 14, 41-43.

Oleson, V. and Whittaker, E. (1968) *The Silent Dialogue: a Study of the Social Psychology of Professional Socialisation*. San Francisco: Jossey Bass.

Oliver, C. (1990) Determinants of interorganisational relationships: integration and future directions. *Academy of Management Review*, 15, 2, 241-265.

Onyett, S. (1997) The challenge of managing community mental health teams. *Health and Social Care in the Community*, 5, 1, 40-47.

Onyett, S. and Ford, R. (1996) Multidisciplinary community teams: where is the wreckage? *Journal of Mental Health*, 5, 1, 47-55.

Onyett, S., Pillinger, T., Müijen, M. (1997) Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health*, 6, 1, 55-66.

Opie, A. (1997) Thinking teams thinking clients: issues of discourse and representation in the work of health care teams. *Sociology of Health and Illness*, 19, 3, 259-280.

Øvretveit, J. (1995) Team decision making. *Journal of Interprofessional Care*, 9, 1, 41-51.

Pavey, A. (1951) *The Story of the Growth of Nursing*. London: Faber and Faber.

Paxton, R. (1995) Goodbye community mental health teams – at last. *Journal of Mental Health*, 4, 331-334.

Peck, E. and Norman, I.J. (1999) Working together in adult community mental health services: exploring inter-professional role relations. *Journal of Mental Health*, 8, 231-242.

Peplau, H. (1987) Tomorrow's world. *Nursing Times*, 83, 1, 29-32.

Peters, T. (1995) *The Pursuit of WOW!* London: Macmillan Press.

Pettigrew, A. and Whipp, R. (1992) *Managing Change for Competitive Success*. London: Blackwell.

Phillips, T., Bedford, H., Robinson, J., Schostak, J. (1994) *Education, Dialogue and Assessment: Creating Partnership for Improving Practice*. London: ENB.

Philo, G., Secker, J., Platt, S., Henderson, L., McLaughlin, G., Burnside, J. (1994) The impact of the mass media on public images of mental illness: media content and audience belief. *Health Education Journal*, 53, 3, 271-282.

Pilgrim, D. and May, C. (1998) Social scientists and the British National Health Service. *Social Sciences in Health*, 4, 1, 42-53.

Pilgrim, D. and Rogers, A. (1999) Mental health policy and the politics of mental health: a three tier analytical framework. *Health Policy and Politics*, 25, 1, 13-23.

Pirrie, A. (1999) Rocky mountains and tired Indians: on territories and tribes. Reflections on multidisciplinary education in the health professions. *British Educational Research Journal*, 25, 1, 113-126.

Porter, R. (1990) *Mind-forged Manacles: a History of Madness in England from the Restoration to the Regency*. London: Penguin.

Porter, S. (1993) Nursing research conventions: objectivity or obfustication. *Journal of Advanced Nursing*, 18, 137-143.

Powell, M. (1999) New Labour and the third way in the British National Health Service. *International Journal of Health Services*, 29, 2, 353-370.

Power, M. (1997) *The Audit Society: Rituals of Verification*. Oxford: Oxford University Press.

Prins, H. (1996) Taking chances: implications for decision makers. *Psychiatric Care*, 3, 5, 181-187.

Provan, K. and Milward, H. (1995) A preliminary theory of inter-organisational effectiveness. *Administrative Science Quarterly*, 40, 1, 1-33.

Quinn, S.M. (1988) *The principals and practice of nurse education* (2nd ed.) London: Chapman Hall.

Rafferty, A.M. (1998) Blurred vision. *The Guardian*, 1/7/98.

Ramon, S. (1986) The category of psychopathology: its professional and social context in Britain. In: Miller, P. and Rose, N. (eds) *The Power of Psychiatry*. London: Polity Press.

Ramos, M. (1992) The nurse patient relationship: theme and variation. *Journal of Advanced Nursing*, 17, 496-506.

Rappaport, J. (1981) In praise of paradox: a social policy of empowerment over prevention. *American Journal of Community Psychology*, 9, 1, 1-25.

Raven, J. and Rix, P. (1999) Managing the unmanageable: risk assessment and risk management in contemporary professional practice. *Journal of Nursing Management*, 7, 201-206.

Reed, J. (1997) Risk assessment and clinical risk management: the lesson from recent inquiries. *British Journal of Psychiatry*, 170 (suppl. 32), April 4-7.

Rhodes, L. (1991) *Emptying Beds: The Work of a Psychiatric Emergency Room*. Seattle: University of Washington Press.

Ritchie, J., Dick, D., Lingham, R. (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.

Rivett, G. (1998) *From the Cradle to Grave: Fifty years of the NHS*. London: King's Fund.

Robinson, D. (1998) *Lost vision and leadership*. 4th Network for Psychiatric Nursing Conference, Oxford, September 2-3.

Rogers, A. and Pilgrim, D. (1991) 'Pulling down churches': accounting for the British mental health users' movement. *Sociology of Health and Illness*, 13, 2, 129-148.

References

Rogers, A and Pilgrim, D. (1993) Service users' views of psychiatric treatments. *Sociology of Health and Illness*, 15, 4, 612-631.

Rogers, A. and Pilgrim, D. (1996) *Mental Health Policy in Britain*. London: Macmillian Press.

Rogers, A. and Pilgrim, D. (1997) *A Sociology of Mental Health and Illness*. London: Macmillian Press.

Rogers, A., Pilgrim, D., Lacey, C. (1993) *Experiencing Psychiatry: Users' Views of Services*. London: Macmillan Press.

Rosenhan, D.L. and Seligman M.E.P. (1989) *Abnormal Psychology* (2nd. Ed.) New York: W.W. Norton.

Roth, J. (1963) *Timetables*. Indianapolis: Bobbs-Merrill.

Ryan, T. (1996) Risk management and people with mental health problems. In: Kemshall, H. and Pritchard, J. (eds) *Good Practice in Risk Assessment and Risk Management*. London: Jessica Kingsley Publications.

Ryrie, I., Agunbiade, D., Brannock, L. and Maris-Shaw, A. (1998) A survey of psychiatric nursing practice in two inner city acute admissions wards. *Journal of Advanced Nursing*, 27, 848-854.

Sackett, D., Richardson, W.S., Rosenberg, W., Haynes, R.B. (1997) *Evidence-based medicine. How to Practise and Teach*. New York: Churchill Livingstone.

Sahlins, M. (1988) *Stone Age Economics*. London: Routledge.

Sainsbury Centre for Mental Health (1997) *Pulling Together: The Future Role and Training of Mental Health Staff*. London: Sainsbury Centre for Mental Health.

Sands, R. (1993) 'Can you overlap here?' a question for an interdisciplinary team. *Discourse Processes*, 16, 4, 545-564.

Scull, A. (1979) *Museums of Madness: The Social Organisation of Insanity in 19th Century England*. London: Allen Lane.

Senge, P. (1990) *The Fifth Discipline: The Art and Practice of the Learning Organisation*. New York: Doubleday.

Shanks, J. and Khera, J. (1995) Better ways of assessing health needs in primary care. *British Medical Journal*, 310, 480-481.

Shepherd, G. (1998) *Key Issues for Implementation of Effective Community Care in the UK*. Sainsbury Conference. York, July 20-22.

Shepherd, G., Murray, A., Müijen, M. (1995) Perspectives on schizophrenia: A survey of user, family carer and professional views regarding effective care. *Journal of Mental Health*, 4, 403-422.

Simons, H. (1987) *Getting to Know Schools in Democracy: The Politics and Process of Evaluation*. Lewes: Falmer Press.

Simpson, A. (1999) Creating alliances: the views of users and carers on the education and training needs of community mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 6, 347-356.

Sjostrom, S. (1997) *Party or patient? Discursive Practices Relating to Psychiatric and Legal Settings*. Umea: Borea.

Skidmore, D. (1994a) *The Ideology of Community Care*. London: Chapman and Hall.

Skidmore, D. (1994b) Can nursing survive? A view through the keyhole. *Nursing Ethics*, 1, 4, 193-199.

Skidmore, D. (1997) *Community Care: Initial Training and Beyond*. London: Arnold.

Skilbeck, M. (1984) *School Based Curriculum Development* London: Harper and Row.

Soni, S., Steers, L., Warne, T. and Sang, W. (1989) Multi-disciplinary teams and line management: practical problems and areas of conflict in clinical psychiatry. *Royal College of Psychiatrists' Psychiatric Bulletin*, 13, 657-661.

Soothill, K., Mackay, L., Webb, C. (1995) *Interprofessional Relations in Health Care*. London: Edward Arnold.

Sparkes, A.C. (1995) Writing people: reflections on the dual crises of representation and legitimation in qualitative inquiry. *Quest*, 47, 2, 158-195.

Stacey, M. (1988) *The Sociology of Health and Healing*. London: Unwin-Hyman.

Stacey, R. (1996) *Strategic Management and Organisational Dynamics*. London: Pitman.

141

Stark, S. (1994) A nurse tutor's experience of personal and professional growth through action research. *Journal of Advance Nursing*, 19, 579-584.

Stark, S., Cooke, P., Stronach, I. (2000) Minding the gap: some theory-practice disjunctions in nursing education research. *Nurse Education Today*, 20, 155-163.

Stark, S. and Elzubeir, M. (1994) Effects of the lack of nurse training on pre-registration midwifery students. *British Journal of Midwifery*, 2, 4, 182-186.

Strathern, M. (2000) The tyranny of transparency. *British Educational Research Journal*, 26, 3, 309-321.

Stronach, I., Allen, J., Morris, B. (1996) Can the mothers of invention make virtue out of necessity? An optimistic deconstruction of research compromises in contract research and evaluation. *British Educational Research Journal*, 22, 4, 493-509.

Stronach, I., Cope, P., Inglis, B., McNally, J. (1994) The SOED 'competence' guidelines for initial teacher training: issues of control, performance and relevance. *Scottish Educational Review*, 26, 2, 118-133.

Szasz, T. (1971) *The Manufacture of Madness*. London: Routledge.

Tennant, D. (1997) Therapeutic mental health nursing in the acute in-patient setting: mission impossible. In: Tilley, S. (ed.) *The Mental Health Nurse: Views of Practice and Education*. Oxford: Blackwell Science.

Thomas, L. and Bond, S. (1995) The effectiveness of nursing: a review. *Journal of Clinical Nursing*, 4, 143-151.

Tilley, S., Pollock, L., Tait, L. (1999) Discourses on empowerment. *Journal of Psychiatric and Mental Health Nursing*, 6, 53-60.

Tsoukas, H. (1997) The tyranny of light. The temptations and paradoxes of the information society. *Futures*, 29, 9, 827-843.

Tudor, K. (1996) *Mental Health Promotion: Paradigms and Practice*. London: Routledge.

Turner, B. (1990) The interdisciplinary curriculum: from social medicine to post-modernism. *Sociology of Health and Illness*, 12, 1, 1-23.

Tyrer, P., Evans, K., Gandhi, N., Lamont, A., Harrison-Read, P., Johnson, T. (1998) Randomised controlled trial of two models of care for discharged psychiatric patients. *British Medical Journal*, 316, 106-109.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) *Code of Professional Conduct for the Nurse, Midwife and Health Visitor*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997) *Register 22, Winter*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1998) *Guidelines for Mental Health and Learning Disabilities Nursing*. April, London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Fitness for Practice. The UKCC Commission for Education Report*, September, London: UKCC.

Van Hoorn, E. (1992) Changes? what changes? The views of the European patients' movement. *The International Journal of Social Psychiatry*, 38, 1, 30-35.

Vincente, B., Vielma, M., Jenner, F.A., Mezzina, R., Lliapas, I. (1993) Users' satisfaction with mental health services. *The International Journal of Social Psychiatry*, 39, 2, 121-130.

Vroom, V. and Yetton, P. (1973) *Leadership and Decision Making*. Pittsburgh: University of Pittsburgh Press.

Waldrop, M. (1994) *Complexity*. London: Penguin.

Walker, A. (1982) *Community Care: The Family, The State and Social Policy*. Oxford: Blackwell.

Warne, T. (1999) *Customs and Contracts in the UK GP Fundholding Scheme*. Unpublished PhD Thesis, Manchester Metropolitan University.

Warne, T., Stark, S., Street, C. (1999) *A Study of Workforce Planning Issues of Nurses Working in Primary Care*. Report commissioned by St Helens and Knowlesy, Liverpool and Sefton Health Authorities. North West Education and Training Consortia, Merseyside.

Warne, T., Skidmore, D., Stark, S., Stronach, I. (forthcoming) A new Bermuda Triangle: policy implications for the education and practice of mental health nurses. *Mental Health Journal*.

References

Waterworth, S. and Luker, K.A. (1990) Reluctant collaborators – do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing*, 15, 8, 971-976.

Webb, A. and Hobdell, M. (1980) Co-ordination and teamwork in the health and personal social services. In: Longsdale, S., Webb, A., Briggs, T. (eds) *Teamwork in the Personal Social Services and Health Care*. London: Croom Helm.

Wells, J. (1997) Priorities, 'street level bureaucracy' and the community mental health team. *Health and Social Care in the Community*, 5, 5, 333-342.

White, E. (1990) *The 3rd Quinquennial Survey of Community Psychiatric Nursing Services*. Research Monograph, Department of Nursing, University of Manchester.

White, E. (1993) Community psychiatric nursing 1980-90: a review of organisation education and practice. In: Brooker, C. and White, E. (eds) *Community Psychiatric Nursing, A Research Perspective Vol. 2*. London: Chapman Hall.

Wilson, V. (1997) Focus groups: a useful method for educational research? *The British Educational Research Journal*, 23, 2, 209-224.

Wilson, J. (1998) Integrated care management. *British Journal of Health Care Management*, 4, 5, 251-253.

Winter, R. (1987) *Action Research and the Nature of Social Inquiry: Professional Innovation and Educational Work*. Aldershot: Avebury Press.

Wolfensberger, W. (1970) The principle of normalisation and its implications to psychiatric services. *American Journal of Psychiatry*, 127, 291-297.

Woodrow, P. (1997) Nurse advocacy: is it in the patient's best interest? *British Journal of Nursing*, 6, 3, 225-229.

Woolf, S., DiGuiseppi, C., Atkins, D., Kameror, D. (1996) Developing evidence based clinical practice guidelines: lessons learned by the preventive services task force. *American Review of Public Health*, 17, 511-538.

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research highlights

Teamworking in Mental Health: Zones of Comfort and Challenge

(Educational Preparation for Mental Health Nursing: Outcomes Evaluation of the Contribution of Mental Health Nurses within the Multi-Professional Multi-Agency Team)

Abstract

This study evaluates the effectiveness of multi-professional multi-agency teamworking in a range of mental health settings, examining both practice and educational preparation. It locates teamwork in terms of the professional role and identity of the mental health nurse, and seeks to develop new understandings of the nature of contemporary professional practice. The research comprises an extensive review of the literature, documentary analysis, focus groups, survey, case studies and report-and-respond survey. It became apparent that teamworking is situated in a *'turbulent'* context in which several *'smoothing mechanisms'* create a series of paradoxes. The study concluded that definitive *'best practice'* was unlikely to fit all situations. We re-conceptualise the role of the mental health nurse, which we feel is in transition and uncertain, with the intention of helping nurses to understand their role in relation to others. In the report we provide a series of educational vignettes as a way of simulating some of the complexity of multi-professional work.

These highlights include a brief overview of the findings and recommendations as a result of the evaluation, together with a description of the methods used.

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Findings

The study was to advise the Board of the implications of the mental health context for educational provision for multi-professional multi-agency teamwork. However, there appears to be a number of conflicts and contradictions in the policy, educational and practice arenas of mental health nursing. Each of these arenas has experienced rapid and unpredicted change. The resulting *'turbulence'* gives rise to disjunctions and tensions in and between discourses, theories and practices. Education alone cannot smooth the turbulence, but we argue that it can help practitioners to understand what causes the turbulence and the effects of it. As a result some questions arise: can (should) educators teach students for such a messy reality? Can we offer students insights into the insulated stories, the separate logics, unintended outcomes and competitive interactions, as well as the more idealistic notions of effective teamworking for quality mental health care? How do we achieve the *'aha!'* of learning about and for teamwork? Will this learning lead to a dilution and distortion of mental health care, or a more dynamic and directed service? In doing so, might some of the issues highlighted here, represented by the contradictions inherent in bringing together policy, practice and education, be avoided in the future preparation of the mental health nurse for multi-professional teamworking?

Multi-professional, multi-disciplinary, multi-agency, inter-professional teamwork and so on is healthy rhetoric, but the research found that there is little hard evidence of institutional transformations based on these ideas and practices. In particular, it is often interesting to ask if the proponents of *'multi-professional teamwork'* actually employ that model as part of their own institutional practice.

Our findings build on the work of Miller et al (1999); Norman et al (1996, 1998). We stressed the need to locate nursing practices and educational preparations for them within a broad understanding both of the changing identity of the mental health nurse, and of the 'turbulent' nature of the context. We saw these as 'nested' concerns. Our recommendations should also be read as a related constellation of changes, rather than as single and specific items which might be separately implemented.

Recommendations

Multi-professional multi-agency teamwork and educational implications

1. We confirm previous research which suggested that teamwork may be more effectively 'caught' than 'taught'. Experiential placements, case studies, educational vignettes and role-play will assist such learning. We found, however, that there were limited opportunities to learn from effective teamwork, even on prolonged placement. Due to various occupational pressures on the workforce, learning-rich placements in this area were not common. Short placements were unsuitable for this sort of learning. We support recent UKCC and ENB suggestions that students undertake longer placements earlier in the pre-registration programme. Such earlier initiation into the practice of the role is also likely to promote a sense of emotional identity as a beginning professional. That emotional identity is necessary to the subsequent development of teamwork approaches. Learning audits, therefore, must attend to 'real' opportunities to 'catch' multi-professional work.

2. Effective teams often rely on individuals being able to 'span' boundaries. These boundaries cross disciplines, and also levels of policy and practice. We recommend greater organisational awareness of such individual roles at macro, meso, and micro levels of policy and practice development, and endorse National Service Framework (DoH, 1999) recommendations for changes in current management development programmes.

3. We find that teamworking is often imposed on work groups without sufficient attention to team building. Students, therefore, are quite likely to experience teamwork as inter-professional 'blaming', or as fragmented inputs. We recommend more attention to team building in work contexts.

4. Teamwork rhetorics stress the collaborative nature of work. Actual examples were more likely to reflect traditional medical models of health care. We recommend that (i) more

collaborative patterns of teamwork be promoted, and (ii) students should learn how to read the distribution of power and authority in groups.

5. Teamworking is not easily taught as a separate subject. It receives little priority from students. It is important, therefore, that teamwork-focused case studies, educational vignettes and assignments should combine such learning with technical nursing issues and user perspectives.

6. Teamwork issues are carried, albeit in small measures, in a curriculum whose modular structures do not model teamwork. We conclude that overall course rationales find little expression in modular provision and that the curriculum is usually fragmented. The absence of visible teamwork in educational provision carries powerful messages to students.

7. There is some evidence to suggest that 'shared learning' does not achieve multi-professional benefits, in line with previous research. Causes were large numbers, inappropriate pedagogy, and lack of uptake by professionals other than nurses. We suggest that 'shared learning' cannot be seen on its own as leading to multi-professional benefits.

8. We find that diagnoses and prescriptions for multi-professional multi-agency practices, or preparations, are over-generalised. These need to be better situated in the actual experiences of mental health nurses in specific work contexts. Such generalisations often refer to work and teamwork conditions that nurses do not actually experience. Such idealisation may be motivated by a desire for education-led improvements in professional practice, but may also result in a damaging gap between ideal and real practice.

9. We find that 'evidence-based' approaches to teamwork learning, or practice, have to be regarded cautiously. Reliable and valid formulae for best practice do not exist, and may not exist in the future. In this area, evidence-based practice must remain an orienting question rather than a definitive prescription.

10. Our findings stress the dynamic and difficult connections between teamwork, role identity, and work context. The emotional costs of the role are not fully addressed by 'evidence-based' approaches to professional work, which stress the rational and procedural nature of work. More account needs to be taken of the affective nature of the nurse's work, both in terms of stress and in terms of vocational commitment.

11. Policy and educational curricula relating to multi-professional multi-agency work seem often to be formulated by those remote from work contexts. Greater involvement of practitioners, at all levels, is desirable, as is the greater involvement of users.

12. We conclude that terms such as 'collaboration', 'partnership' and 'teamworking' are difficult to understand and bring about unless issues of power, status, authority and competition between disciplines and within hierarchies are made part of professional learning at pre- and post-registration levels.

13. We offer the notions of 'economy of performance' and 'ecology of practice' as ways of understanding the tensions and contradictions of the mental health role in times of change. We believe that students could and should be taught, via case studies and educational vignettes, to understand the conflictual pressures of professional performance in contemporary conditions of continuous change. Such an understanding might help students avoid the sorts of 'ideal versus real' schisms that can lead readily to cynicism. It might also help managers to understand the sorts of dilemmas continuous change and conflictual demands place on professionals in health settings.

14. Some problems of multi-professional learning, especially at the pre-registration phase, are soluble only with smaller cohorts, staggered intakes, and more generic approaches to professional education. There is clear evidence that considerations of cost act against educational effectiveness in this area.

15. The evidence is clear that practitioners, doctors and students generally agreed

that a shorter common foundation programme and an earlier introduction of specific mental health inputs was desirable in the pre-registration programme.

16. The development of programmes remains uni-professional. We support the logic of different professions contributing equally to the development of multi-professional and multi-agency programmes, as is beginning to happen in post-registration programmes.

Policy Issue

17. Our study has implications for understanding some of the dynamics of policy change in mental health settings. We posit that policy directions tend to accumulate sufficient illogic and contradiction to prompt their periodic reversal, and apply this to the higher education versus 'apprenticeship' debate. The danger of overreacting to such 'pendulum' swings is asserted.

Evidence- and research-based practice

18. Evidence-based approaches to professional practice need to be accompanied by evidence-based approaches to policy and management. We note a disjunction in these different arenas of work, and suggest that research-based approaches are most needed at policy levels.

User involvement

19. On the basis of our research, we conclude that service user involvement, in many aspects of mental health care, is minimal. Barriers to inclusion are poorly understood and we suggest further research in this area. We advocate a greater involvement of the user or ex-user in policy, practice and educational contexts.

20. There is little evidence that multi-professional, multi-agency approaches actually benefit the user, directly or indirectly. While the mediated nature of such benefits is clear, and the difficulty of comparison considerable, it would be desirable to evaluate more certainly the efficacy of such approaches. Research into teamworking may benefit from multi-professional multi-agency commissioning.

General issues

21. The evidence suggested that notions such as 'competencies', 'audit' and 'accountability' can oversimplify the nature of work outcomes and skew professional delivery towards readily measurable outcomes. Both in practice and in professional preparation, the limits of the usefulness of these approaches needs to be understood and shared with learners.

22. More generally, we are convinced that the 'turbulent' nature of policy, practice and educational contexts means that prescriptions for best practice are often expressed in unrealistic and utopian terms. Education needs to become more focused on the messy realities of care, as well as collaboration.

23. We are not persuaded that the trend towards universal prescription (national specification of competencies, role definitions etc.) is desirable. Diversity of provision, reasonably based, carries with it the prospect of a variety which may be optimal for a system in circumstances of rapid change. It also offers a greater prospect of local relevance, user involvement, and the more certain 'ownership' of course philosophy.

Method

To achieve the aims of the evaluation a mixed methodological approach was used incorporating data collected via five Aspects:

- **Aspect 1:** An extensive literature review to gain a deeper understanding of the 'turbulent' mental health context. In addition, a documentary analysis of curricula at pre- and post-registration levels, as well as influential policy documents in mental health was undertaken. This enabled us to trace the ways in which national policy is translated into course philosophy at institutional level via nursing models and curriculum models, and eventually into modular provision.

- **Aspect 2:** A series of local focus groups with mental health service users, carers, nurses and managers, multi-professional team members, tutors and students. These groups provided an orientation to the issues involved in the evaluation.

- **Aspect 3:** A national survey in eight regions across England (n=800) administered to those groups of individuals stated above. This provided an overview of the perceptions of individuals and identified further lines of enquiry for the fieldwork.

- **Aspect 4:** A total of 101 days spent in eight case study sites across England interviewing and observing a range of individuals working in a variety of mental health care settings.

- **Aspect 5:** A national report-and-respond survey (n=400) which provided interim feedback on earlier Aspects (reporting) and provoked further comment (responding) in relation to these findings.

We collected data using an inductive approach based on a form of grounded theory (Aspects 2 & 4). This involved tracing a variety of job performances of the mental health nurse in different work and team contexts, and then seeking the implicit, or explicit, models of professional practice, as well as the knowledge-use strategies employed by the professional in taking practical decisions. We also used a deductive approach based on describing and then understanding the processes through which prescription becomes, or fails to become, action (Aspects 1, 3 & 5).

Further, the orienting focus groups, initial survey, case studies and the returns from the report-and-respond survey, give the findings both empirical depth and breadth. The exploration of case study themes and issues in the report-and-respond survey help test the generalisability of case findings, maximising opportunities for 'progressive focusing', and to make theorising a continuous feature of the inquiry. Our analysis of the data combines elements of grounded theory emanating from the survey and the case studies, as well as drawing on relevant theories of professionalism, multi-professionalism, needs analysis, evidence- and research-based practice. In addition, we feel that some of the central concerns of our work, like 'effectiveness' and 'congruency', imply a comparative dimension to the study, especially in relation to issues concerning multi-professional multi-agency settings. The need to understand the innovation in context was reflected in the 'ecological' approach that we took.

The methodology enabled the effectiveness of the mental health nurses' role, including their role as a member of a multi-professional team, to be examined. A triangulation of service users' needs, managers' perceptions, fellow professionals' perceptions etc. was used. Further, it then highlighted the match or mismatch between such performance and prior education and training. Appraising role effectiveness against educational congruence enabled overall judgements of educational worth and the identification of the implications for educational provision and evidence-based professional knowledge to be developed.

Our approach to the research does not offer definitive judgements on the relationship between the discrete role of the mental health nurse within the multi-professional multi-agency team in a range of care settings, and the educational provision for these roles. However, we think it offers the best outcome in relation to meeting the needs of formative and timely feedback to the ENB, as well as informing a contextualised summative judgement on the current situation, and in doing so, contributes to the development of evidence-based professional knowledge.

Further information

For copies of the Research Highlights and the Report, please contact:

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Project Details

The evaluation was a two year study (January 1998 - January 2000) commissioned by the English National Board for Nursing, Midwifery and Health Visiting. Its findings will contribute to the wider philosophical debates about professionalism and teamworking, and mental health nursing policy, education, research and practice in general. It will be of interest to a wide range of individuals connected with mental health care.

References

Department of Health (1999) *Our Healthier Nation: Mental Health National Service Framework.* The Stationery Office, London.

Miller C., Ross N. & Freeman M. (1999) *Shared Learning and Clinical Teamwork: New Directions in Education for Multiprofessional Practice.* ENB, London.

Norman I., Peck E. & Richards H. (1998) *Interprofessional Working in Adult Community Mental Health Services: Setting a Positive Agenda.* King's Fund, London.

Norman I., Redfern S., Bodley D., Holroyd S., Smith C. & White E. (1996) *The Changing Educational Needs of Mental Health and Learning Disabilities Nurses.* ENB, London.

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Dr. Warne, Dr. Skidmore and Ms. Cotton have a background in Mental Health Nursing, in addition to Mr. Montgomery. Dr. Stark and Professor Stronach have expertise in educational evaluation.

RESEARCH HIGHLIGHTS

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